**Board of Directors**  
**Public AGENDA** *(held in public)*

**Date:** Tuesday 26 September  
**Time:** 0830hrs – 1100hrs  
**Venue:** Boardroom, Executive Corridor, Level D, Rotherham Hospital

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**Assurance Framework**

**Regulatory and Statutory Reporting**

**Escalations to Board of Directors**

**Board Governance**

**To ensure smooth transaction of business, the Chairman will invite questions from the public at the end of the meeting only.**

In accordance with §152(4) of the Health and Social Care Act, 2012, a copy of this agenda has been provided to Governors prior to the Board Meeting.
BOARD MEETING: 26 September 2017

Agenda item: 334/17

Report: Consideration for Patient Stories at Board of Directors

Presented by: Ellie Monkhouse, Chief Nurse
Author(s): Ellie Monkhouse, Chief Nurse

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B1, B6
Corporate Risk Register: no specific identified risks

Purpose of this paper:

Patient stories have been presented at board for some time by the Chief Nurse. The stories consist of a positive and negative patient story or experience. These stories normally come from complaints and incidents where we are able to gain consent for the use of their story.

The current format is a verbal presentation by the Chief Nurse.

The purpose of this paper is to make some proposals on this process in the future.

Summary of Key Points:

Options:

1. To continue with the current format
2. Provision of written format for trust boards
3. Presentation from staff on behalf of division
4. Asking patients to attend the board meetings to present and discuss with board members
5. A video to be presented to board about a patient’s experience

Board action required:

For decision.
Consideration for patient stories at Board

1. Introduction:

1.1 Patient stories have been presented at board for some time by the Chief Nurse. The stories consist of a positive and negative patient story or experience. These stories normally come from complaints and incidents where we are able to gain consent for the use of their story.

1.2 The current format is a verbal presentation by the Chief Nurse.

1.3 The purpose of this paper is to make some proposals on this process in the future.

2. Context:

2.1 The presentation of patient stories in a board setting have been used for some time across both provider and commissioning organisations. They allow the board to hear of an experience that a patient, relative or carer has experienced whilst using our services. They seek to gain assurance that the organisation is learning from individual experiences.

2.2 There are some potentially complex issues to try and resolve if seeking a patient to attend to present their story in a public board setting. We must consider how we would maintain their own confidentiality, so would therefore need to gain consent, but we must consider that not all patients may be happy to share their story with potential media and public interest.

2.3 A random review of other organisations plan for patient stories has been considered as part of this proposal, as well as a discussion with Head of Communications and Patient Experience Team.

2.4 There continues to be a struggle to find meaningful patient stories that are spread across the trust, and don't just relate to nursing care. The move towards directorates to present and explore how their divisional performance or changes have resulted from a poor experience has allowed them to be accountable for the care they provide and evidence changes. This is something that more organisations have been moving towards, rather than the story always coming from the Chief Nurse Team. A story could be about a service or transformation of service, not just about a poor experience.

3. Options:

3.1 To continue with the current format
3.2 Provision of written format for trust boards
3.3 Presentation from staff on behalf of division
3.4 Asking patients to attend the board meetings to present and discuss with board members
3.5 A video to be presented to board about a patient’s experience
4. **Discussion:**

4.1 **Option 1:**
Continue with same process of a monthly verbal report to board or a positive and a negative story.

4.2 **Option 2:**
Some trusts provide a written report on a patient story and present to trust board. This would enable all board members to read the information/material. This would allow maintenance of confidentiality, but has the disadvantage of interpretation by individual or author.

4.3 **Option 3:**
Some trusts asks divisions on a rotational basis to present in a format of their choice. Presented by Divisions who have worked with patient and have a rapport with them to help with facilitation and preparation on a quarterly basis, therefore having a presentation from each division per year as part of the board planning process.

4.4 **Option 4:**
Patients in attendance to present their own stories. The advantage of this is that the board are able to hear directly from the patient without editing or interpretation. The disadvantages would be providing support before, during and after presentation and allowing enough time, within the time constraints of the board timings to be able to allow a richness to the conversation and presentation. To ensure support and that confidentiality is respected would take careful planning and facilitation. This would need arranging quite a way in advance with the divisions to ensure a patient was able to be identified.

4.5 **Option 5:**
The provision of a short video or audio presentation either at the private board meeting, or in public. Whilst this would allow the patient to not have to be present in a public board setting, it would mean that resource would need to be found within the Communications Team to meet with the Patient, film, edit and prepare the story. Time allocation for this has been identified at approximately 4 to 5 hours.

5. **Preferred Options:**
   - Option 3, this appears to be a process used by other organisations.
   - Option 5, this could be supported by the PALs team when in place within the trust.

6. **Conclusion:**

6.1 The selection of a patient story method needs careful consideration, due to time constraints, support, and facilitation and confidentiality reasons.

7. **Recommendations:**

7.1 The role of presenting patient stories to board should also come from divisions, this appears to be becoming more popular as a way of providing evidence of triangulating divisional plans and data with changes to service Improvement.

7.2 Consider potential media interest if presented in public.
7.3 The role of the Transformation agenda needs to be considered when considering the future of presenting patient stories as a way of identifying a case for change based on local perspective and experience.

7.4 The Board is asked to consider their preferred option, and agree time scales for implementation.

Ellie Monkhouse
Acting Chief Nurse
September 2017
MINUTES OF THE PUBLIC BOARD OF DIRECTORS MEETING HELD ON TUESDAY 29 AUGUST 2017 IN THE BOARDROOM, LEVEL D

Present: Mr M Havenhand, Chairman
         Mrs L Barnett, Chief Executive
         Mrs G Atmarow, Non-Executive Director
         Mr J Barnes, Non-Executive Director
         Mrs C Clements, Director of Workforce
         Mr M Edgell, Non-Executive Director
         Ms L Hagger, Non-Executive Director
         Mr B Mellor, Non-Executive Director
         Mrs E Monkhouse, Acting Chief Nurse
         Dr P Smith, Non-Executive Director
         Dr C Wareham, Medical Director

In attendance: Ms A Milanec, Director of Corporate Affairs / Company Secretary
                Miss D Stewart, Corporate Governance Manager (minutes)
                Mrs M Dennis, Director of Operations
                Mr M Bloy, Deputy Director of Finance (representing Director of Finance)

Apologies: Mrs H Craven, Non-Executive Director
          Mr C Holt, Director of Strategy and Transformation
          Mr S Sheppard, Director of Finance

Observers: Members of staff x2
           Public Governors x3
           Members of the Public x1

296/17 CHAIRMAN’S WELCOME AND APOLOGIES FOR ABSENCE

Mr Havenhand welcomed those present to the meeting with any apologies having been RECEIVED and NOTED.

QUALITY AND SAFETY

297/17 PATIENT STORY

The two patient stories, one of a positive and one of a negative nature, were presented by the Acting Chief Nurse.

Mrs Monkhouse used the negative story to outline the experience of a patient and their family following an unwitnessed fall whilst on the Clinical Decision Unit.

Whilst the fall had been documented within the patient’s medical case note, the family had not been contacted at the time and had only become aware of
the incident when visiting their relative. As a result of the concerns raised, bespoke training around falls and dementia had been undertaken by the unit and wider directorate. Additionally, the Trust-wide policy for the transfer of patients had been reviewed.

The family had been assured that improvements had been undertaken following the concerns raised and had expressed their wish that the experience be shared with the Board.

The positive story was a letter of appreciation from a patient regarding their experience whilst under the care of Mr Cresswell, Consultant General Surgeon.

PROCEDURAL ITEMS

298/17 DECLARATIONS OF CONFLICTS OF INTERESTS

There were no conflicts of interest declared.

299/17 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 25 July 2017 were AGREED as correct record subject to the following amendments.

i. Monthly Integrated Performance Report (minute 260/17 refers)

Fourth paragraph, final sentence to read:

The four hour access target also remained challenging and an area for concern.

ii. Finance Report (minute 260/17(d) refers)

Third paragraph from the bottom to read:

In response, Mrs Clements indicated that the level of expenditure was £3m less in 2016/17 than the previous year. There was a better understanding of the position, areas of improvement were being seen following enhanced controls, and expenditure was beginning to level off.

300/17 MATTERS ARISING FROM THE PREVIOUS MEETING

There were no matters arising from the previous meeting which were not either covered by the agenda or action log.

301/17 ACTION LOG

The Board of Directors CONSIDERED and DISCUSSED the Board action log, with a number agreed to be formally closed or those which would continue to be monitored.
With regard to log number 38. Whilst the action was agreed to be closed, Mr Mellor would meet with the Trust’s Health and Safety Officer to discuss the requirement to quality assure the organisational health and safety arrangements for contractors who provided services to the Trust.

**ACTION – BM**

**STRATEGY AND STRATEGIC PLANNING**

**302/17 REPORT FROM THE CHAIRMAN**

The Board of Directors RECEIVED and NOTED the report from the Chairman.

Mr Havenhand specifically highlighted the activities of the Rotherham Together Partnership, which had been established for two years, with the Board noting that Councillor Chris Read had been appointed as Chair. This would be with immediate effect, and for a period of three years.

With regard to the Acute Care Collaboration Vanguard, following the agreement to align board meeting across the Partnership further consideration had been given to the matter by the Trust Secretaries. This had been to take into account availability of critical data for some organisations, with a revised proposal being documented within the report.

The Board AGREED the revised proposal that board meetings would continue to be held on the last Tuesday of the month, rather than on the fourth Tuesday in the month. In effect this would result in no change for the Rotherham Board meetings, and would align with the majority of other Trusts in the Vanguard.

Mrs Atmarow informed the Board that as documented within the report she had been impressed by the facilities for dementia patients and the level of care provided within the main hospital building and the Fern Unit. In addition Mrs Monkhouse informed the Board that Beth Goss Hill, Lead Nurse Dementia Care, had been appointed by Dementia UK as an Admiral Nurse. Such nurses provided the specialist dementia support that families need and worked in the community, in care homes, in hospices and hospitals. Mr Havenhand would arrange to meet with Mrs Goss-Hill.

**ACTION - MH**

The Board of Directors NOTED the Chairman’s report.

**303/17 REPORT FROM THE CHIEF EXECUTIVE**

The Board of Directors RECEIVED the report from the Chief Executive in relation to strategic issues, financial, quality and operational matters and stakeholder engagement.

Mrs Barnett took the opportunity to highlight a number of specific sections from within her report. The first related to the continued focus being given to deliver the milestones and enablers against the operational objectives. The quarter two milestones were considered to be on track and remained the focus of operational committees, with transparency of progress through the respective Board Committees.
The financial position was poor, with significant variance having been seen in month. The Director of Operations in conjunction with the Divisions had developed robust recovery plans, with consideration being given to further schemes to achieve efficiency savings to mitigate the risk.

Performance against the 4 hour access target had been extremely challenging. Although performance during the day had seen 95% being achieved, there continued to be significant issues overnight. An improvement plan was in place with the aim that 90% would be achieved in September.

Due to current performance in relation to finance and the 4 hour access target, Mr Edgell questioned if the operational objectives were focused on the most appropriate matters for the Trust.

Mrs Barnett indicated that she considered comprehensive plans were in place for both the 4 hour access target and financial recovery, with additional scrutiny and advice being sought external to the organisation to ensure plans were robust. There remained confidence that the elements identified should improve performance.

The Board continued to discuss specific challenges with regard to the Emergency Department which included the requirement for a strong and cohesive team, progress with regard to a command and control approach, the positive impact to be made once the two newly appointed Consultants joined the team, and challenges seen during the night period. The key to positive progress would be implementation of the action plan and at an increased pace.

Mrs Barnett re-emphasised that these two matters were the main areas of concern and therefore focus for the Trust, which was also in line with national expectations, scrutiny and focus.

Mr Havenhand took the opportunity at this point to read a letter received from the Secretary of State for Health congratulating the Trust on the Friends and Family Test scores. A copy of the letter would be circulated to the Board.

ACTION - MH

With regard to stakeholder engagement there continued to be traction within the South Yorkshire and Bassetlaw Accountable Care System and Working Together Programme.

The Board of Directors NOTED the update from the Chief Executive.

304/17

ANNUAL BUSINESS PLANNING

The Board of Directors RECEIVED the report from the Chief Executive which outlined the proposed approach to be taken with regard to the annual business planning process for 2018/19.

In addition, tabled at the meeting was the proposed timetable of actions to be taken each month and the specific meetings where the matter would be considered. Whilst the document outlined the approach to be taken, Mrs
Barnett indicated that she had a further updated version and would circulate this to the Board.

**ACTION – LB**

Mrs Barnett indicated that the purpose of the approach and timetable would be to ensure completion and sign off of the plans by December 2017. Whilst the timetable had been based on 2016/17 planning process, guidance for 2017/18 had yet to be released by NHS Improvement and as such the proposed timetable may require adjustment in the future.

The planning process, including the agreement of expectations and planning principles, would be considered at the 12 September 2017 Board seminar.

The Board in discussing the proposed timetable suggested that agreement of the Cost Improvement Programme be added to the timetable for February 2018. Additionally, the annual review of the Five Year strategy should be made more explicit within the timetable and a review of the 2 year contract with Rotherham Clinical Commissioning Group added.

**ACTION – LB**

The Board of Directors NOTED the proposed approach for the 2018/19 business planning process.

**OPERATIONAL PERFORMANCE**

**305/17 MONTHLY INTEGRATED PERFORMANCE REPORT**

The Board of Directors RECEIVED and NOTED the monthly Integrated Performance Report (IPR).

Before moving to the detailed reports from the Executive Directors, Mrs Barnett highlighted a number of specific areas from the report.

The top achievements in month had been 18 week referral to treatment performance which, for July, placed the Trust as one of the best performing trusts out of 144 providers. Performance against the 62 day cancer standard for June showed 86.8% compliance compared to the national performance of 80.4%.

The most improved areas had been sickness absence rates, with the 12 month rolling sickness absence being 4.43%, which was a decrease on the June position. This had been the lowest rolling percentage since 2013/14. Another area of improvement had been diagnostic waiting times with only 0.2% of patients waiting longer than 6 weeks for one of the 15 key diagnostic tests. However, the position remained challenging in some areas and as such would be a focus for the Performance Meetings to be held later in the week with the aim to ensure robust and resilient plans were in place.

Areas of key concern remained four hour access performance and the financial position.

With regard to the format of the report it was considered that the colour rating for C2 (% of complaints responded to within agreed timescales) should be red
rather than green as documented. Post meeting note – it had been confirmed that the rating should have been red.

Mrs Barnett confirmed that the A&E activity position within the report had not been rebased to take into account the Walk-in Centre, however this would be reflected in the next report.

ACTION - CH
The Board of Directors NOTED the new Integrated Performance Report.

305/17(a) QUALITY REPORT
The Board of Directors RECEIVED and NOTED the Quality Report presented by the Acting Chief Nurse and Medical Director.

Mrs Monkhouse reported that in relation to Harm Free Care, the classic safety thermometer score for community had improved from 87.21% to 91.74% with the target being 95%. The yet to be validated position for August was 94%.

Mrs Monkhouse wished to place on record her gratitude to the community team for the support they had given during the work which had been undertaken to understand the data, its collection and interpretation which had resulted in the significant improvement being seen. It was anticipated that the position would continue to improve.

With regards to complaints, it was disappointing to report that response times against the 30 working days target had yet again decreased to 33% against the 95% target. This matter had also been an escalation from the Quality Assurance Committee. Whilst some Directorates were achieving the required target, challenges remained within Integrated Medicine, which unfortunately was impacting on overall performance.

The Governance Report highlighted the comments from the new head of the Parliamentary and Health Service Ombudsman in relation to complaints handling and that training would be made available to NHS complaints’ staff. Once available the Trust would need to ensure that it was engaged in the training.

Additionally, the Board recognised the benefits to be harnessed from a Patient Advice and Liaison Service (PALS) in relation to complaints. Establishment of such a service was one of the objectives for 2017/18, with the business case for one of the enablers to be considered by the Business Investment Committee in September.

In relation to healthcare associated infections Dr Wareham highlighted the continued good performance, with quarter one seeing no cases of C Difficile or MRSA bacteraemia. There had been two cases of C Difficile in July with one root cause analysis meeting having been concluded and the other ongoing.

Mrs Atmarow took the opportunity to question progress with regard to the management of policies and procedures in the context of the actions being
progressed to respond to the Care Quality Commission requirement notice Regulation 17. There appeared to be lack of progress in relation to Trust wide policies and procedures which was concerning as these documents were fundamental to the provision of high standards of care and it was important that they were up to date.

In response, Mrs Monkhouse outlined progress to date which included a review of definitions and processing a backlog of documents. With regards to the latter Mrs Barnett confirmed that the documents would in the future be accessible to staff through Share Point to facilitate ease of access and transparency of requirements. As this matter was a Trust wide issue, the Chairman requested that a timeline be developed for completion of this work which would be provided for the next Board meeting.  

ACTION – EM

The Board of Directors NOTED the Quality Report.

305/17(b) OPERATIONAL PERFORMANCE REPORT

The Board of Directors RECEIVED and NOTED the Operational Performance Report, which was presented by the Director of Operations.

Performance against the four hour access target remained challenging. A meeting had been held between the A&E Delivery Board, NHS England and NHS Improvement to review performance.

A discussion took place regarding key aspects of the A&E improvement plan and whilst it was considered that all possible actions were being taken, which included external support and advice, there was concern regarding the extent to which the actions being implemented were having the desired improvement on performance. In order to ensure a whole organisation focus to improve the patient experience, a trust-wide summit would be held on 29 September 2017 to ensure organisational engagement to deliver the four hour standard.

Other operational targets, as referenced by the Chief Executive, were generally performing well.

Operationally, the focus remained on delivery of both the 4 hour access target and financial recovery. With regard to the latter the divisions had compiled robust plans progress against which was being monitored fortnightly in addition to weekly by the General Managers with the Director of Finance.

The first draft of the Winter Plan was progressing.

Associated with both winter planning and facilitating early discharge, Mr Mellor highlighted the impact on patient flow as a result of insufficient planning for medication on discharge which was being evidenced from a number of sources.

Mrs Dennis confirmed that the ward dashboard will provide the data on this matter in order that it could be addressed in the relevant areas. Mr Havenhand expressed his disappointment that the issue of delayed medication was once
again impacting on discharges as it had been considered that this enabler had been resolved. It was important that the matter was addressed and compliance maintained.

On a similar matter, Mr Edgell questioned if there was an escalating matter in relation to delayed discharges. Mrs Dennis informed the Board that a detailed multi-disciplinary action plan, as the matter related to a number of agencies not solely the Trust, had been agreed. Additionally, an external review had highlighted areas for further improvement as well as good practice already in place.

The Board of Directors NOTED the report and operational challenges.

**WORKFORCE REPORT**

The Board of Directors RECEIVED the Workforce Report presented by the Director of Workforce.

With regard to staffing levels, it was reported that progress was being seen in relation to Consultant recruitment. Due to the re-launch of the Master Vendor contract the Trust has had increased access to a number of agencies to improve fill rates, however as a result this had increased the financial costs. Sickness absence rates continued to improve over the rolling 12 month period.

Mandatory and Statutory Training (MAST) compliance rates stood at 84.71% for core subjects against the target of 85%. Mrs Clements indicated that additional support was being provided to the Division of Medicine to improve their compliance rates.

Due to concerns previously raised regarding compliance with safeguarding training, a deep dive was being undertaken through the Divisions, with an update scheduled to be provided to the Strategic Workforce Committee in September.

With regard to apprenticeship activity the report outlined the areas where the forty apprentices would be assigned at the end of September 2017. Mrs Clements would ascertain if any of the five apprentices for the Information Technology department would include clinical coders as a previous commitment had been given to support in house development of these posts.

**ACTION - CC**

In response to a question from Dr Smith, clarity was provided in relation to nursing apprenticeship; with the alternative options being pursued by the Trust outlined to members with assurance being given that the Trust was well placed with regard to nurse training. The matter would be discussed by the Strategic Workforce Committee as part of the deep dive review of apprenticeship.

**ACTION - CC**

Mrs Atmarow expressed her concerns regarding the number of nursing vacancies, as identified within the report and from comments within the organisation, and whilst it had been indicated a number of options were being pursed these would take time to implement and she sought assurance that the matter was being addressed.
Mrs Clements confirmed that whilst 53 newly qualified nurses would commence in post in September, there remained circa 46 Band 5 vacancies. A skill mix review would be undertaken in coming months, although current benchmarking placed the Trust in a good position. Mrs Monkhouse added that the comments identified a requirement for increased education with the workforce on future plans and services.

Oversight on these matters - vacancies and the skill mix review - would remain within the remit of the Strategic Workforce Committee.

The Board of Directors NOTED the Workforce Report with additional information on the leadership programme and apprenticeship levies to be included in the next report.

305/17(d) **FINANCE REPORT**

The Board of Directors RECEIVED and NOTED the month four finance report presented by the Deputy Director of Finance.

The financial position had been discussed at length at the Finance and Performance Committee meeting held on 21 August 2017 and also at a meeting with NHS Improvement.

Performance at month four showed a deficit of £7,983k against a £5,651k deficit plan, which was an adverse variance of £2,332k. There were three key factors for the in-month position. The first was a review of the depreciation charges which highlighted a historic system error equating to £400k. This had been resolved with proactive reporting processes now in place for early identification of similar issues.

The second factor was the activity position, which was below plan for July equating to £700k. The reasons for this were multi factorial, with some matters still being investigated. The final factor was pay costs which were £600k adrift in month.

Against the cost improvement programme (CIP) target of £8.5m, as at the end of July, £7.1m had been identified, with a full year effect of £5.1m. The CIP Delivery Board was meeting fortnightly in recognition of the requirement to bridge the gap and increase the pace of identification and delivery of schemes.

The capital programme for the first four months stood at £1,228k compared to the cumulative budget of £1,050k. However, the end of year forecast out-turn was £3,184k against the annual budget of £3,273k.

The cash balance for July was £1,703k, which included receipt of the monthly deficit funding and working capital support, compared to the planned £1,354k.

The financial sustainability risk rating was 4.
In terms of financial recovery, robust plans had been developed by the Divisions which would be monitored through weekly meetings including General and Service Managers and the Executive Directors.

In opening the item to debate, Mr Havenhand sought assurance that the reasons for the position being off plan were understood and that the recovery plans would resolve the matter to ensure delivery at the year end.

Mrs Barnett confirmed that in relation to the three in month factors the position was understood in relation to depreciation and pay. With regard to activity, whilst the variance could be seen in the data, the divisions did not agree that the data accurately reflected the activity. Therefore additional work was being undertaken to review the matter and until that was concluded she was not assured on the position. The outcome of the review, once completed, would be provided to the Finance and Performance Committee and shared with the whole Board.

**ACTION - SS**

With regard to the CIP position Mr Mellor questioned the decrease in the full year effect of the plans as at the previous meeting the reported position had been £5.9m with the figure now stated as £5.1. Mrs Barnett indicated that the plans would be reviewed the next day with the actual position to be communicated to the Board.

**ACTION – SS**

Remaining on the subject of the CIP, the Chairman sought clarity on the quality impact assessments (QIA) position as they were crucial in providing assurance regarding the schemes being put forward. Dr Wareham confirmed that significant progress had been made with regard to the sign off of QIAs in readiness for discussion at the September Quality Assurance Committee.

In concluding the discussion, Mr Havenhand stated that the financial position was a serious issue to be addressed by the organisation. There remained concern, and indeed frustration, that technical issues were still being highlighted which were not helping the fragile financial position. There remained an opportunity to rectify the position through the recovery plan which would need to be closely monitored by the Finance and Performance Committee, with additional assurance being provided between their meetings as necessary.

The Board of Directors NOTED the month four finance report.

**306/17 MORTALITY REPORT**

The Board of Directors RECEIVED the Mortality Report presented by the Medical Director.

Dr Wareham outlined the current position with regard to mortality with HMSR (Hospital Standardised Mortality Ratio) being 107, which was a reduction on the February 2017 figure of 110. This indicated the position was plateauing, with steps continuing to be taken to address the matter, which had included further discussion with NHS Improvement on any further actions which could be taken.
Mr Edgell confirmed that the Quality Assurance Committee remained appraised of the mortality position, including a deep dive discussion taking place at the August meeting. Whilst the committee were not happy with the figures, they were content with the actions being taken to address the matter. Having reviewed the period in question QAC considered that there was nothing more which could have been done at the time and anticipated that as a result of the attention being given to the matter, the figures would reduce in due course.

The Board of Directors NOTED the Mortality Report.

**307/17 **

**MEDICAL ENGAGEMENT PLAN**

The Board of Directors RECEIVED the Medical Engagement Plan presented by the Medical Director.

Dr Wareham explained that the report outlined the current position and plans to improve medical engagement in the future.

The Board of Directors NOTED the Medical Engagement Plan which would be overseen by the Strategic Workforce Committee.

**ASSURANCE FRAMEWORK**

**308/17 **

**GOVERNANCE REPORT**

The Board of Directors RECEIVED the Governance Report from the Director of Corporate Affairs/Company Secretary.

Ms Milanec highlighted to the Board the revisions proposed by NHS Improvement to the Single Oversight Framework (SOF) as documented in the report. As part of the consultation process, which had closed on 18 September 2017, Ms Milanec had on behalf of the Trust responded to the eight questions posed on the revised framework.

In addition, the new Use of Resources assessment framework element of the SOF would be effective from 1 September 2017, this would see NHSI periodically undertaking use of resources reviews at individual organisations.

NHSI would be consulting with the Care Quality Commission to re-evaluate the segmentation of organisations. Currently, the Trust was in segment 3 (Providers receiving mandated support for significant concerns) on the scale of 1 (providers with maximum autonomy) to 4 (special measures). Ms Milanec confirmed that once the Trust’s re-evaluation was known it would be communicated to the Board.

**ACTION - AM**

Following attendance at a NHSI seminar on ‘Effective Report Writing’ for Board and Board Committees, the benefits of utilising Statistical Process Control Charts Seminar had been evident and she would recommend their use for board reports.

The Board of Directors NOTED the Governance Report
309/17  BOARD ASSURANCE FRAMEWORK

The Board of Directors RECEIVED the quarter one Board Assurance Framework (BAF) report presented by the Director of Corporate Affairs/Company Secretary.

Ms Milanec indicated that each Board Committee had considered the strategic risks assigned to them, with the risks (inherent, residual and risk appetite) having been discussed in detail, with the suggested amendments documented within the report.

The Board of Directors APPROVED the amendments, as recommended by the Board Committees, for BAF items, B3, B4, B5, B9, B10, and B11, which in many cases resulted in an increased risk rating. As recommended by the Company Secretary it was AGREED these high risk BAF areas would receive more focus and attention at future Board Committee meetings.

**ACTION – AM**

The Strategic Workforce Committee during their consideration of the BAF had raised the matter of amending the risk descriptor for BAF item B7. Following discussion by the Board, it was AGREED that due to the similarity with BAF item B6, BAF item B7 should actually be removed.

There was also a suggestion that in light of the discussions held at the meeting the risk score for BAF item B6 should be revisited or whether there was a requirement for a new BAF risk relating to compliance.

**ACTION – AM**

310/17  BOARD COMMITTEES TERMS OF REFERENCE

The Board of Directors RECEIVED the report from the Director of Corporate Affairs/Company Secretary which provided the revised terms of reference for four board assurance committees. These were:

i. Finance and Performance Committee
ii. Quality Assurance Committee
iii. Strategic Workforce Committee
iv. Strategy and Transformation Committee

The Board of Directors APPROVED the terms of reference.

311/17  REVISED BUSINESS CASE PROCESS

The Board of Directors RECEIVED and NOTED the report from the Director of Finance which outlined the revised Business Case process, which was presented by the Deputy Director of Finance.

Mr Bloy indicated that whilst the process for approving business cases would still follow that prescribed in the Trust’s Standing Financial Instructions, the business case template had been revised.

Future business cases would now follow the Five Case Model as defined by Treasury guidance. In addition, as part of the structured mandatory Healthcare
Financial Management Association development/training programme planned for all budget holders there was a module which provided an overview of business cases which would be utilised.

Whilst acknowledging that the proposed report template followed national best practice, both Mrs Monkhouse and Dr Wareham expressed their concern that there appeared to be no reference to patient outcomes or quality metrics within the template or supporting guidance. As such, Mr Bloy was requested to address this matter within the documentation.

**ACTION – MRB**

The Board NOTED the progress which had been made in relation to the business case process, with the final documentation to be submitted to the September 2017 meeting.

**ACTION - SS**

**REGULATORY AND STATUTORY REPORTING**

**312/17 RESPONSIBLE OFFICER ANNUAL REPORT**

The Board of Directors RECEIVED the Responsible Officer Annual Report presented by the Medical Director.

Dr Wareham provided background information on the process and indicated his recommendation that the Chief Executive sign the 2016/17 Statement of Compliance on behalf of the designated body.

The Board of Directors APPROVED the Responsible Officer Annual Report, including the signing of the Statement of Compliance. Mrs Barnett requested that before the documentation was submitted the data contained within appendix one relating to audit of all missed or incomplete appraisal audit 2016/17 be rechecked.

**ACTION – CW**

**BOARD GOVERNANCE**

**313/17 REGISTER OF DIRECTORS’ INTEREST**

The Board of Directors RECEIVED the report from the Director of Corporate Affairs/Company Secretary, which formally presented the Register of Directors’ Interest as part of its twice yearly submission to the Board.

The Board of Directors APPROVED the register.

**314/17 REVIEW OF BOARD ANNUAL PLANNER**

The Board of Directors RECEIVED and APPROVED its forward annual planner, with a number of amendments having been suggested.

**315/17 ANY OTHER BUSINESS**

There were no matters of any other business.
DATE OF NEXT MEETING

The next meeting of the Board of Directors would be held on Tuesday, 26 September 2017.

At this point the Chairman opened the meetings to any questions or comments from the observers, to which there was none.

Martin Havenhand
Chairman
<table>
<thead>
<tr>
<th>Log No</th>
<th>Meeting</th>
<th>Report/Agora title</th>
<th>Minute Ref</th>
<th>Agenda item and Action</th>
<th>Lead Officer</th>
<th>Timescale/Deadline</th>
<th>Comment/ Feedback from Lead Officer(s)</th>
<th>Open/Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>28-Mar-17</td>
<td>Patient Story</td>
<td>106/17</td>
<td>Execs to consider inviting patients themselves to attend BoD to provide their patient story in person</td>
<td>ChN</td>
<td>31/03/2018- 26/09/2017</td>
<td>Written report provided from Acting ChN - to be addressed under item 334/17 of September Board agenda</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>36</td>
<td>27-Jun-17</td>
<td>Data Quality report</td>
<td>216/17</td>
<td>NAO - archiving of test results - CH to ascertain the Trust's position</td>
<td>DS&amp;T</td>
<td>25/07/2017- 29/08/2017- 26/09/2017</td>
<td>Trust Data Retention Policy and Health Records Policy in place. Local SOPS also in place. In addition, the Trust is undergoing an archiving review, which includes input from clinicians. 29/8/17: BoD requested that the action be left open as the response did not address the question of how the Trust is assured that appropriate policies are being complied with. Company Secretary has provided assurance that this particular type of incident is unlikely to occur at the Trust due to the non-mail processes used.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>51</td>
<td>25-Jul-17</td>
<td>IPR: Workforce Report</td>
<td>260/17</td>
<td>Management of annual leave KPIs to be included in future reports</td>
<td>DoW</td>
<td>29/08/2017- 26/09/2017</td>
<td>Verbal update on KPIs to be provided to meeting by DoW. KPIs exist in e-rostering and annual leave matters covered in agency report</td>
<td>Open</td>
</tr>
<tr>
<td>52</td>
<td>25-Jul-17</td>
<td>IPR: Workforce Report</td>
<td>260/17</td>
<td>Include in the monthly report, how successful management of annual leave over summer period was and its impact on the organisation</td>
<td>DoW</td>
<td>26-Sep-17</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>55</td>
<td>25-Jul-17</td>
<td>SFIs</td>
<td>265/17</td>
<td>Delegation of approval, after further minor amends, to SS, LB, JB, MH</td>
<td>DoF</td>
<td>14/08/2017- 30/09/2017</td>
<td>To be resolved by end of September 2017</td>
<td>Open</td>
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<td>Log No</td>
<td>Meeting</td>
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<td>Comment/ Feedback from Lead Officer(s)</td>
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<tr>
<td>58</td>
<td>25-Jul-17</td>
<td>Escalations from Governors</td>
<td>269/17</td>
<td>To be added to action log: 3 staff governor vacancies out of 5 remain vacant. Execs to consider options available to co-op colleagues to ensure they are engaged and represented.</td>
<td>DoW</td>
<td>31-Oct-17</td>
<td>Ongoing</td>
<td>Open</td>
</tr>
<tr>
<td>59</td>
<td>25-Jul-17</td>
<td>Board Planner</td>
<td>272/17</td>
<td>12 month rolling programme of proposed meeting dates to be included next month</td>
<td>Co Sec</td>
<td>29/08/2017 26/09/2017</td>
<td>Proposed 2017/18 dates for 12 months now appear on board planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>60</td>
<td>29-Aug-17</td>
<td>Action Log</td>
<td>301/17</td>
<td>(Arising from closed action 38). Mr Mellor to meet Health and Safety Officer to discuss quality assurance of health and safety arrangements for contractors</td>
<td>BM</td>
<td>26-Sep-17</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>61</td>
<td>29-Aug-17</td>
<td>Report from the Chairman</td>
<td>302/17</td>
<td>Chair to meet Beth Goss Hill following appointment as Dementia UK Admiral Nurse</td>
<td>Chair</td>
<td>26-Sep-17</td>
<td>Complete</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>62</td>
<td>29-Aug-17</td>
<td>Report from Chief Executive</td>
<td>303/17</td>
<td>Copy of letter received from Secretary of State for Health to be circulated to Board</td>
<td>Chair</td>
<td>26-Sep-17</td>
<td>Complete</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>63</td>
<td>29-Aug-17</td>
<td>Annual Business Planning</td>
<td>304/17</td>
<td>Copy of revised timetable to be circulated to Board</td>
<td>CEO</td>
<td>26-Sep-17</td>
<td>(Will be discussed as part of the planned discussions to take place on 26 Sept after the Board meeting.)</td>
<td>Open</td>
</tr>
<tr>
<td>64</td>
<td>29-Aug-17</td>
<td>Annual Business Planning</td>
<td>304/17</td>
<td>Further additions and clarifications to be added to timetable</td>
<td>CEO</td>
<td>26-Sep-17</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>65</td>
<td>29-Aug-17</td>
<td>Monthly Integrated Performance Report</td>
<td>305/17</td>
<td>A&amp;E position to include UECC walk-in-centre figures</td>
<td>DS&amp;T</td>
<td>26-Sep-17</td>
<td>Complete</td>
<td>Recommend to close</td>
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<tr>
<td>Log No</td>
<td>Meeting Date</td>
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<td>Minute Ref</td>
<td>Agenda item and Action</td>
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<tr>
<td>66</td>
<td>29-Aug-17</td>
<td>Quality Report</td>
<td>305/17(a)</td>
<td>Timeline for conclusion of work regarding production of a database of policies to provided to Board</td>
<td>CN</td>
<td>26-Sep-17</td>
<td>Action plan provided as part of the Quality Report on the agenda at item 344/17(a)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>67</td>
<td>29-Aug-17</td>
<td>Workforce Report</td>
<td>305/17(b)</td>
<td>Confirmation required if any of the 5 apprentices for IT mentioned in the report were part of the coding dept</td>
<td>DoW</td>
<td>26-Sep-17</td>
<td>None were part of coding dept.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>68</td>
<td>29-Aug-17</td>
<td>Workforce Report</td>
<td>305/17(b)</td>
<td>Nursing apprentices to be discussed as part of a deep dive at QAC</td>
<td>DoW</td>
<td>26-Sep-17</td>
<td>To be carried forward on the QAC planner</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>69</td>
<td>29-Aug-17</td>
<td>Workforce Report</td>
<td>305/17(b)</td>
<td>More information on leadership programme and apprenticeship levies to be included in next board report</td>
<td>DoW</td>
<td>26-Sep-17</td>
<td>Complete</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>70</td>
<td>29-Aug-17</td>
<td>Finance Report</td>
<td>305/17(d)</td>
<td>Outcome of review regarding activity to be provided to FPC and shared with rest of board</td>
<td>DoF</td>
<td>25-Sep-17</td>
<td>Specific paper on information concerns to be considered by FPC (25/09/207). DoF &amp; DS&amp;T to provide update to Board</td>
<td>Open</td>
</tr>
<tr>
<td>71</td>
<td>29-Aug-17</td>
<td>Finance Report</td>
<td>305/17(d)</td>
<td>Exact CIP position to be shared with Board</td>
<td>DoF</td>
<td>26-Sep-17</td>
<td>Part of Public Board agenda at item 344/17(d)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>72</td>
<td>29-Aug-17</td>
<td>Governance Report</td>
<td>308/17</td>
<td>Any change to (NHSI) segmentation to be communicated to Board</td>
<td>Co Sec</td>
<td>26-Sep-17</td>
<td>This would be raised as a matter of course at the time as part of the Co Secretary role. (Business as usual.)</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>73</td>
<td>29-Aug-17</td>
<td>Board Assurance Framework</td>
<td>309/17</td>
<td>High risk BAF items to be given focus at each Board Committee</td>
<td>Co Sec</td>
<td>31-Oct-17</td>
<td>To be addressed a part of Q2 update to Board.</td>
<td>Open</td>
</tr>
<tr>
<td>74</td>
<td>29-Aug-17</td>
<td>Board Assurance Framework</td>
<td>309/17</td>
<td>Revisit risk score for B6 and consider if new risk was required related to compliance</td>
<td>Co Sec</td>
<td>26-Sep-17</td>
<td>On Board agenda at item 348/17.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>75</td>
<td>29-Aug-17</td>
<td>Revised Business Case Process</td>
<td>311/17</td>
<td>Documentation to be addressed in relation to patient outcomes and quality metrics</td>
<td>DoF</td>
<td>26-Sep-17</td>
<td>On Board agenda at item 348/17.</td>
<td>Recommend to close</td>
</tr>
<tr>
<td>76</td>
<td>29-Aug-17</td>
<td>Revised Business Case Process</td>
<td>311/17</td>
<td>Documentation to be resubmitted to September meeting for approval</td>
<td>DoF</td>
<td>26-Sep-17</td>
<td>On Board agenda at item 348/17.</td>
<td>Recommend to close</td>
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<tr>
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<tr>
<td>77</td>
<td>29-Aug-17</td>
<td>Responsible Officer</td>
<td>312/17</td>
<td>Before statement of compliance being signed by CEO, data in appendices to be checked</td>
<td>MD</td>
<td>31-Aug-17</td>
<td>Checked and completed.</td>
<td>Recommend to close</td>
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<tr>
<td></td>
<td></td>
<td>Annual Report</td>
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</table>
Report: Report from the Chairman

Presented by: Martin Havenhand, Chairman
Author(s): Lisa Reid, Head of Governance

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance: NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference: BAF: All as appropriate
Corporate Risk Register: All as appropriate

Purpose of this paper:
This paper provides an overview of progress on key issues since my last report to the Board.

Summary of Key Points:

1. Since our September Board meeting our Executive colleagues have been working extremely hard on preparing and implementing a Financial Recovery Plan to ensure we deliver the 2017/18 financial plan.
2. I was asked to attend the Quarterly Review Meeting with NHS Improvement as they are concerned about our financial position to date and also our A&E performance.
3. We are establishing a time limited board sub group to focus on our actions to improve our A&E performance.
4. The Chief Executive and I met with the Programme Director for the Hospital Services Review across the South Yorkshire and Bassetlaw Accountable Care System.
5. Visit to Research & Development department

Board action required:
The Board is asked to note the report.
1.0 Introduction

1.1 This report provides an update on the activities since the last Board Meeting, with which I have been involved.

2.0 Financial position

2.1 Since our September Board meeting our Executive colleagues have been working extremely hard on preparing and implementing a Financial Recovery Plan to ensure we deliver the 2017/18 financial plan.

3.0 NHSI Quarterly Review Meeting

3.1 The Executive Directors and I met with NHS Improvement (NHSI) on 14 September for our Quarterly Review Meeting. I was asked to attend the Quarterly Review Meeting with NHS Improvement as they are concerned about our financial position to date and also our A&E performance.

4. A&E Performance

4.1 In response to the Board’s concerns regarding the 4 hour A&E access standard, it has been agreed that a short term Task and Finish Group be established, members of which will be the Chairman, Lynn Hagger, Gabby Atmarow, Paul Smith, the Chief Executive and the Director of Strategy and Transformation.

4.2 The Group is being established only up until 31 December 2017.

4.3 The purpose of the Group is to seek assurance on behalf of the Board that the actions that the Trust is currently taking to achieve a return to the required 95% target, are having the desired effect, and that they will lead to sustained, improved performance.

5.0 Acute Care Collaboration Vanguard (Working Together Partnership - Provider)

5.1 On 1 September, Louise Barnett and I met with Alexandra Norrish, Programme Director, in relation to the Hospital Services Review which is currently underway.

6.0 Chairman activities

6.1 On Monday 11 September 2017 I attended the memorial service for John Silker, our Partner Governor representing the Barnsley and Rotherham Chamber of Commerce following his death last month.

6.2 I am also sad to report that Bridget Dixon who served as the Public Governor for Rother Valley South for 6 years also recently passed away.

6.3 The Board Seminar took place on 12 September and included items on Annual Business Planning, the financial recovery plan and A&E improvement plan as well as updates from the Non-Executive Directors in relation to their roles as ‘buddies’ with each of the four clinical divisions.

6.5 I chaired the third meeting of the Shadow Board on 15 September.

6.6 I spoke to Beth Goss-Hill, the Trust’s Lead Dementia Nurse on 18 September in order to pass on the Board of Directors’ congratulations on her recent appointment as an Admiral Nurse for Dementia UK.

6.7 Tony Pedder, Chairman of Sheffield Teaching Hospitals NHS Foundation Trust, and I met up on 18 September for our annual discussion of issues relevant to both our organisations.

6.8 I visited the Research and Development Department on 19 September and I have asked for an item to be put on our forward workplan to update the board about our R&D activity.

6.9 On 19 September I met with the Lead Governor Dennis Wray and had a very productive meeting relating to the Governor engagement.

Martin Havenhand
Chairman
September 2017
Report: Report from the Chief Executive

Presented by: Louise Barnett, Chief Executive
Author(s): Louise Barnett, Chief Executive

Strategic Objective:
- Patients: Excellence in healthcare
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations
- Partners: Securing the future together

Regulatory relevance:
- NHSI: Licence Condition FT4 / Single Oversight Framework
- CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
- BAF: All as applicable
- Corporate Risk Register: All as applicable

Purpose of this paper:
This paper outlines progress regarding a number of key strategic and operational issues and stakeholder engagement since the last Board of Directors meeting.

Summary of Key Points:
- Progress continues against the operational objectives, a full review of the objectives will be undertaken at the end of Quarter 2.
- Performance in relation to the 4 hour access target and finance continue to be challenging and remain a key area of focus across the organisation.
- We continue to engage with stakeholders across Rotherham and South Yorkshire and Bassetlaw to ensure the delivery of high quality care.

Board action required:
For noting
1.0 Introduction

1.1 This paper outlines progress regarding a number of key strategic and operational issues and stakeholder engagement since the last Board of Directors’ meeting.

2.0 Strategic Issues

2.1 The Trust has a series of strategic objectives and milestones, together with 16 operational objectives and 6 enablers, each with associated milestones and Executive and operational leads.

2.2 In terms of delivery, there are 88 milestones due for completion by the end of quarter two, of which 20 have been achieved, 47 are on track and 21 are at risk of delivery.

2.3 To support the delivery of milestones regular meetings are taking place with each Division/Corporate leads, the Strategy & Transformation Team and key project managers to ensure progress continues.

2.4 A detailed summary of progress is shared with the Strategic and Transformation (Assurance) Committee monthly.

2.5 However, in light of the ongoing challenges outlined below in terms of the financial position and performance against the four hour access target, a piece of work is underway which reviews the extent to which the objectives support these aims in order to further prioritise resource as we move into quarter 3. A separate report will be provided to the board in October which will outline progress to date and the outcome of the review with next steps.

3.0 Performance issues

3.1 The Integrated Performance Report highlights the key performance within the Trust along with the top achievements and key concerns. I have highlighted the two key areas of concern below; financial performance and four hour access standard.

3.2 Financial performance continues to be challenging, in terms of in-month and year to date performance, which are both adverse to plan, particularly pay spend. A strengthened delivery plan is in place, which is been driven by clinical divisions and corporate teams. Stronger governance arrangements are in place to ensure transparency of progress, supported by the introduction of a weekly flash report, which gives early sight of pay spend and activity levels, to support focus on and delivery of key actions. Workforce shortages continue to create pressure on substantive teams, who remain reliant on temporary colleagues, which continues to drive levels of premium and agency spend above plan. Recruitment remains a key priority.

3.3 Whilst there have been a number of days where the Trust has achieved performance above 95% against the four hour access standard, and primary care streaming is going well, overall performance is still below expected levels, which is impacting on patients in terms of their waiting time and overall experience. An improvement plan is in place with weekly oversight to ensure clarity of actions and identification of support where needed, to the leadership teams to drive improved outcomes. Workforce issues remain a priority.
3.4 In addition, significant work is going into preparing for winter, both within the Trust and with partners. Despite plans last year, the system response was not sufficient to cope with pressures and therefore additional actions are required this year. A number of actions are in train but further actions are needed. This will be overseen by the A&E Delivery Board.

3.5 The GP out of hours service which is now located in the urgent and emergency care centre is due to transfer shortly and the board will be updated on progress at the meeting.

4.0 Stakeholder engagement

4.1 Trust colleagues continue to work with partner organisations to improve the efficiency, resilience and sustainability of services across the Trust and South Yorkshire and Bassetlaw (SYB) through the Accountable Care System (ACS) and Working Together Programme/ Acute Care Collaboration Vanguard.

4.2 The monthly meetings of the Working Together Programme/ Acute Federation Executive meeting and Trust Chairs and Chief Executive meeting, took place on 4 September 2017. I chaired the Informatics workstream on 15 September 2017, and also met with Dr Richard Cullen who is the lead for the ACS digital workstream regarding the alignment and focus on key priorities.

4.3 An event was held for ACS key stakeholders on 5 September 2017, which was facilitated by Chris Ham, Chief Executive of The Kings Fund. Michael Macdonnell from the NHS England strategy team and national lead for ACS development also attended the session.

4.4 The approved minutes of the SYB Collaborative Partnership Board held in July 2017 are attached for information. No meeting was held in August and the monthly meetings resumed on 8 September 2017.

4.5 The independent ACS Hospital Services Review has commenced, led by Chris Welsh, the independent Chair and clinical lead. Sir Jonathan Michael has been engaged to provide peer support to Chris Welsh and the review team and Alexandra Norrish is engaged as the Programme Director. Deloitte have been appointed to support the work. A presentation was shared with the Health and Wellbeing Board in September and engagement activities led by the review team are underway with stakeholders including the Trust. Conrad Wareham is the Lead Executive Director for this review. Conrad and I will apprise the board of progress.

4.6 The A&E Delivery Board took place on 13 September 2017. This was heavily focused around winter planning to ensure that all partners are taking proactive steps to ensure resilience during this period.

4.6 During September, the regular meetings of the Rotherham Integrated Health and Social Care Place Board, Rotherham Together Partnership Chief Executive Officer Group and Health and Wellbeing Board took place.

4.7 I chaired the Yorkshire and Humber Regional Leadership Council meeting on 7 September 2017.
4.8 The regular quarterly review meeting with NHSI took place on 14 September 2017 which focused around key areas of performance.

5.0 Conclusion

5.1 The key areas of focus remain the financial position and four hour access performance whilst ensuring delivery against other key standards and engagement in the ACS and Hospital Services Review, to ensure high quality care for the population of Rotherham.

Louise Barnett
Chief Executive
September 2017
South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

14 July 2017

The Boardroom, 722 Prince of Wales Road

Decision Summary

<table>
<thead>
<tr>
<th>Minute reference</th>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>73/17</td>
<td>Matters arising</td>
<td>SK</td>
</tr>
<tr>
<td></td>
<td><strong>65/17</strong> Sharon Kemp informed members that a meeting will take place in August for Local Authorities and CCG Chairs to discuss the work each organisation is progressing in their respective areas. Sharon Kemp added that proposals emerging from the meeting will be useful to feed into the Collaborative Partnership Board (CPB) and a paper will be brought for members consideration at the meeting in September 2017.</td>
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</tr>
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<td>74/17</td>
<td>National Update</td>
<td>KT</td>
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<td></td>
<td>Kevan Taylor suggested that it would be useful to know the impact of workforce shifts and an agreement that there should be a no banding approach. Kevan Taylor should approach Ben Chico for information relating to this matter.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Will Cleary Gray added that the planned engagement meetings will be part of the wider communications strategy that will be coming to the Oversight and Assurance Group meeting and the Collaborative Partnership Board for discussion.</td>
<td>HS</td>
</tr>
<tr>
<td></td>
<td>The Chair added that there will also be a report brought to the Collaborative Partnership Board regarding the rebranding for the ACS in September.</td>
<td>HS</td>
</tr>
<tr>
<td>75/17</td>
<td>ACS Memorandum of Understanding</td>
<td>Local Authority CEO’s</td>
</tr>
<tr>
<td></td>
<td>Sharon Kemp informed members that Local Authorities are meeting together mid-August 2017 and will therefore provide feedback on the MOU by mid-September 2017.</td>
<td></td>
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<tr>
<td></td>
<td>The Chair added:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The MOU was not a legal document, it is a high level</td>
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framework allowing us to negotiate with the Centre.

- The MOU will have gone through most governing bodies for support by the end of July 2017.
- Local authorities will liaise with Will Cleary-Gray outside this meeting regarding their timeline and a form of words to support the MOU.
- Will Cleary-Gray should draw up a shortened version of this MOU that could be used by Local Authorities for their meeting during August.
- Will Cleary-Gray will bring any issues back to the next Board meeting.

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<tr>
<td></td>
<td>Professor Welsh presented to the Collaborative Partnership Board (slides will be circulated after this meeting).</td>
</tr>
<tr>
<td></td>
<td>The Chair informed members that:</td>
</tr>
<tr>
<td></td>
<td>- Will Cleary-Gray will liaise with Alexandra Norrish to ensure Chief Executives are contacted regarding discussions that she needs to progress.</td>
</tr>
<tr>
<td></td>
<td>- Will Cleary-Gray and Jackie Pederson will review the process regarding Overview and Scrutiny – testing out that in each place all organisations are included.</td>
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<tr>
<td></td>
<td>- Ensure timescales to approach Healthwatch are brought forward.</td>
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<tr>
<td></td>
<td>- The Acute Hospital Services Review should be an agenda item on the providers meeting on 31st July 2017.</td>
</tr>
<tr>
<td></td>
<td>- AO’s and CCG’s to consider if they require a similar meeting to the providers meeting that is happening on 31st July 2017.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>78/17</th>
<th>Connection and Workforce Framework</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Peter Hall added the draft report is out for review and comments and contributions are welcomed. A report will be brought to Collaborative Partnership Board members regarding strategic proposals.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>80/17</th>
<th>Commissioning Reform and Development of Accountable Care Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Idris Griffiths was invited to present the paper on this subject (the presentation will be circulated to members).</td>
</tr>
</tbody>
</table>
South Yorkshire and Bassetlaw Sustainability and Transformation Partnership

Collaborative Partnership Board

Minutes of the meeting of

14 July 2017

The Boardroom, 722 Prince of Wales Road

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Designation</th>
<th>Present</th>
<th>Apologies</th>
<th>Deputy for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sir Andrew Cash</td>
<td>South Yorkshire and Bassetlaw ACS</td>
<td>ACS Lead/Chair and CEO, Sheffield Teaching Hospitals NHS FT</td>
<td>✓</td>
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<tr>
<td>Adrian Berry</td>
<td>South West Yorkshire Partnership NHS FT</td>
<td>Deputy Chief Executive</td>
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<td>✓</td>
<td>Rob Webster CEO</td>
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<tr>
<td>Adrian England</td>
<td>Healthwatch Barnsley</td>
<td>Chair</td>
<td>✓</td>
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<tr>
<td>Ainsley Macdonnell</td>
<td>Nottinghamshire County Council</td>
<td>Service Director</td>
<td>✓</td>
<td></td>
<td>Anthony May CEO</td>
</tr>
<tr>
<td>Alison Knowles</td>
<td>Locality Director North of England, NHS England</td>
<td></td>
<td>✓</td>
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<tr>
<td>Amy Fell</td>
<td>Yorkshire Ambulance Service NHS Trust</td>
<td>Planning and Development Trainee Manager</td>
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<td></td>
<td>Accompanied Matthew Sandford</td>
</tr>
<tr>
<td>Anthony May</td>
<td>Nottinghamshire County Council</td>
<td>Chief Executive</td>
<td></td>
<td>✓</td>
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<tr>
<td>Ben Chico</td>
<td>Working Together Partnership Vanguard</td>
<td>Project Manager</td>
<td>✓</td>
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<tr>
<td>Ben Jackson</td>
<td>Academic Unit of Primary Medical Care, Sheffield University</td>
<td>Senior Clinical Teacher</td>
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<tr>
<td>Brian Hughes</td>
<td>NHS Sheffield Clinical Commissioning Group</td>
<td>Director of Commissioning</td>
<td>✓</td>
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<td>Maddy Ruff</td>
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<tr>
<td>Catherine Burn</td>
<td>Voluntary Action Representative</td>
<td>Director</td>
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<tr>
<td>Chris Edwards</td>
<td>NHS Rotherham Clinical Commissioning Group</td>
<td>Accountable Officer</td>
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<tr>
<td>Chris Welsh</td>
<td>South Yorkshire and Bassetlaw ACS</td>
<td>Independent Chair of the Acute Hospital Services Review</td>
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<tr>
<td>Debbie Hilditch</td>
<td>Healthwatch Doncaster</td>
<td>Representative</td>
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<tr>
<td>Des Breen</td>
<td>Working Together Partnership Vanguard</td>
<td>Medical Director</td>
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<tr>
<td>Diana Terris</td>
<td>Barnsley Metropolitan Borough Council</td>
<td>Chief Executive</td>
<td>✓</td>
<td></td>
<td>John Mothersole CEO</td>
</tr>
<tr>
<td>Greg Fell</td>
<td>Sheffield City Council</td>
<td>Director of Public Health</td>
<td>✓</td>
<td></td>
<td>John Mothersole CEO</td>
</tr>
<tr>
<td>Frances Cunning</td>
<td>Yorkshire &amp; the Humber PHE Centre</td>
<td>Deputy Director – Health &amp; Wellbeing</td>
<td>✓</td>
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</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Role</td>
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<tr>
<td>Helen Stevens</td>
<td>South Yorkshire and Bassetlaw ACS</td>
<td>Assc. Director of Comms &amp; Engagement</td>
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<tr>
<td>Ian Atkinson</td>
<td>NHS Rotherham Clinical Commissioning Group</td>
<td>Deputy Chief Officer</td>
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<tr>
<td>Idris Griffiths</td>
<td>NHS Bassetlaw Clinical Commissioning Group</td>
<td>Accountable Officer</td>
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<tr>
<td>Jackie Holdich</td>
<td>NHS Barnsley Clinical Commissioning Group</td>
<td>Head of Delivery (Integrated Primary/Out of Hospital Care)</td>
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<tr>
<td>Jackie Pederson</td>
<td>NHS Doncaster Clinical Commissioning Group</td>
<td>Accountable Officer</td>
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<tr>
<td>Jane Anthony</td>
<td>South Yorkshire and Bassetlaw ACS</td>
<td>Corp Admin, Exec PA, Business Manager</td>
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<tr>
<td>Janette Watkins</td>
<td>Working Together Partnership Vanguard</td>
<td>Director</td>
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<tr>
<td>Jeremy Cook</td>
<td>South Yorkshire and Bassetlaw ACS</td>
<td>Interim Director of Finance</td>
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<tr>
<td>John Mothersole</td>
<td>Sheffield City Council</td>
<td>Chief Executive</td>
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<tr>
<td>John Somers</td>
<td>Sheffield Children’s Hospital NHS Foundation Trust</td>
<td>Chief Executive</td>
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<tr>
<td>Julia Burrows</td>
<td>Barnsley Council</td>
<td>Director of Public Health</td>
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<tr>
<td>Kathryn Singh</td>
<td>Rotherham, Doncaster and South Humber NHS FT</td>
<td>Chief Executive</td>
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<tr>
<td>Kevan Taylor</td>
<td>Sheffield Health and Social Care NHS FT</td>
<td>Chief Executive</td>
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<tr>
<td>Lesley Smith</td>
<td>NHS Barnsley Clinical Commissioning Group</td>
<td>SYB ACS System Reform Lead, Chief Officer, NHS Barnsley CCG</td>
<td></td>
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<tr>
<td>Louise Barnett</td>
<td>The Rotherham NHS Foundation Trust</td>
<td>Chief Executive</td>
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<tr>
<td>Louise Nunn</td>
<td>SYB ACS</td>
<td>Assistant Head of Finance</td>
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<tr>
<td>Maddy Ruff</td>
<td>NHS Sheffield Clinical Commissioning Group</td>
<td>Accountable Officer</td>
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<tr>
<td>Matthew Groom</td>
<td>NHS England Specialised Commissioning</td>
<td>Assistant Director</td>
<td></td>
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<tr>
<td>Matthew Sandford</td>
<td>Yorkshire Ambulance Service NHS Trust</td>
<td>Associate Director of Planning &amp; Dev</td>
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<tr>
<td>Mike Curtis</td>
<td>Health Education England</td>
<td>Local Director</td>
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<tr>
<td>Neil Taylor</td>
<td>Bassetlaw District Council</td>
<td>Chief Executive</td>
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<tr>
<td>Paul Moffat</td>
<td>Doncaster Children’s Services Trust</td>
<td>Director of Performance, Quality and Innovation</td>
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<tr>
<td>Paul Smeeton</td>
<td>Nottinghamshire Healthcare NHS Foundation Trust</td>
<td>Chief Operating Executive</td>
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<tr>
<td>Peter Hall</td>
<td>Peter Hall HR</td>
<td>HR Consultant</td>
<td></td>
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<tr>
<td>Richard Henderson</td>
<td>East Midlands Ambulance Service</td>
<td>Chief Executive</td>
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<tr>
<td>Richard Jenkins</td>
<td>Barnsley Hospital NHS Foundation Trust</td>
<td>Chief Executive</td>
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</tbody>
</table>
70/17 Welcome and introductions
The Chair welcomed members to the meeting.

71/17 Apologies for absence
The Chair noted apologies for absence.

72/17 Minutes of the previous meeting held 9th June 2017
The minutes of the previous meeting were agreed as a true record.

73/17 Matters arising

67/16 SCR/STP Health Led IPS Employment Service. The Chair informed members this was a huge £8m project coming into our Accountable Care System (ACS). Kevan Taylor informed members this would be a 3 year funded project which would help people with mental health and learning disabilities to secure and retain work. Procurement for the project will be starting soon and will be using the Sheffield CCG and combined authorities. Health representation concerning the governance of this project will be via Kevan Taylor and Jackie Pederson.

65/17 Sharon Kemp informed members that a meeting will take place in August for Local Authorities and CCG Chairs to discuss the work each organisation is progressing in their respective areas. Sharon Kemp added that proposals emerging from the meeting will be useful to feed into the Collaborative Partnership Board (CPB) and a paper will be brought for members consideration at the meeting in September 2017.
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<tr>
<td><strong>National Update</strong></td>
</tr>
<tr>
<td>The Chair gave members the following update on national issues concerning the ACS:</td>
</tr>
<tr>
<td>There will be an all day meeting with the Secretary of State on 19th July 2017 that he will be attending with Will Cleary-Gray. The meeting will cover discussions on:</td>
</tr>
<tr>
<td>- Metrics for measuring the 44 STP’s (national scorecards).</td>
</tr>
<tr>
<td>- A capital announcement.</td>
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<tr>
<td>- Development of ACS and National support.</td>
</tr>
<tr>
<td>The Chair and Will Cleary-Gray attended a meeting on 13th July 2017 with NHS England and NHS Improvement and had discussions on the context of the programme with regards to:</td>
</tr>
<tr>
<td>- The post-election legal framework.</td>
</tr>
<tr>
<td>- Workforce and industrial relations.</td>
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<tr>
<td>- Financial discussions.</td>
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<tr>
<td>The Chair added that at the NHS England and NHS Improvement meeting he conveyed that he envisages this ACS will:</td>
</tr>
<tr>
<td>- Have a development phase (1st October 17 to 31st March 17), a shadow phase (1st April 18 to 31st March 18) and an operational phase (1st April 2019).</td>
</tr>
<tr>
<td>- Focus on the 3 major projects at place level: the Acute Hospital Services Review, the Commissioning Review and pushing back office functions all supported by transformation programme in each place/ACP and across the ACS.</td>
</tr>
<tr>
<td>- Progress when it is ready, and therefore, there is the facility in the MOU to extend the phases if required. It is important that we are a cohesive organisation.</td>
</tr>
<tr>
<td>NHS England and NHS Improvement have agreed the national scorecards and we want to determine the elements of our local scorecards e.g. educational attainment, career ladders within our organisations, addressing health inequality issues.</td>
</tr>
<tr>
<td>Kevan Taylor suggested that it would be useful to know the impact on workforce shifts and an agreement that there should be a no banding approach. Kevan Taylor should approach Ben Chico for information relating to this matter.</td>
</tr>
<tr>
<td>The Oversight and Assurance Group met on 12th July 2017 and decided to progress arranging the following meetings in the coming months:</td>
</tr>
<tr>
<td>- Audit Committee Chairs to discuss governance</td>
</tr>
<tr>
<td>- Bringing Non Executive and lay members of boards and governing bodies together to discuss the common agenda of working together.</td>
</tr>
<tr>
<td>- Governors of Foundation Trusts.</td>
</tr>
<tr>
<td>- Councillors in local authorities.</td>
</tr>
<tr>
<td>- Arranging a conference for 200-300 people (something with a similar membership of the old Guiding Coalition group) to</td>
</tr>
</tbody>
</table>

**KT**
ensure membership is up to date on matters.

Suzy Brain England and Helen Stevens will be leading on the last four meetings identified above. Will Cleary Gray added that the planned engagement meetings will be part of the wider communications strategy that will be coming to the Oversight and Assurance Group meeting and the Collaborative Partnership Board for discussion.

The Chair added that there will also be a report brought to the Collaborative Partnership Board regarding the rebranding for the ACS in September.

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<th>ACS Memorandum of Understanding</th>
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<tr>
<td>Will Cleary-Gray updated members on the progress of the Memorandum of Understanding (MOU). The MOU has been developed in conjunction with Collaborative Partnership Board members from March 2017 to June 2017. Feedback has been incorporated into the MOU and a final document has been circulated to Collaborative Partnership Board members to obtain support from their governing bodies and this process should be complete by the end of July 2017.</td>
<td></td>
</tr>
<tr>
<td>The MOU formed part of the assessment of South Yorkshire and Bassetlaw STP and it was required in order to become an Accountable Care System.</td>
<td></td>
</tr>
<tr>
<td>Sharon Kemp informed members that Local Authorities are meeting together mid-August 2017 and will therefore provide feedback on the MOU by mid-September 2017.</td>
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The Chair added:
- The MOU was not a legal document, it is a high level framework allowing us to negotiate with the Centre.
- The MOU will have gone through most governing bodies for support by the end of July 2017.
- Local authorities will liaise with Will Cleary-Gray outside this meeting regarding their timeline and a form of words to support the MOU.
- Will Cleary-Gray should draw up a shortened version of this MOU that could be used by Local Authorities for their meeting during August.
- Will Cleary-Gray will bring any issues back to the next Board meeting. |

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<td>The Chair welcomed Professor Chris Welsh who is the South Yorkshire &amp; Bassetlaw Accountable Care System Independent Director of the Acute Hospital Services Review to the meeting.</td>
<td></td>
</tr>
<tr>
<td>Professor Welsh presented to the Collaborative Partnership Board (slides will be circulated after this meeting).</td>
<td></td>
</tr>
<tr>
<td>The presentation provided members with an update of the Review’s design principles, objectives, working definition of sustainability, approach and high level programme plan, communications and engagement strategy, methodology for initial short-listing of services.</td>
<td></td>
</tr>
<tr>
<td>Professor Welsh added the following comments:</td>
<td></td>
</tr>
</tbody>
</table>
• The final report is due with the Oversight and Assurance Group on 28th April 2018 and there is zero time contingency in the plan to accommodate any delay.
• Drafts will be brought to Collaborative Partnership Board in due course.
• The number of people involved in this review is significant and due to time constraints involved conversations may not be in person therefore technology will be used to assist in the process.
• The recommendations for one service could be applicable to others in the region.
• Work will carry on after the review and it could take 5-10 years to create a cultural change.
• The majority of people requiring hospital care will still receive their care locally.

Members commented:
• Peter Taylor from the workforce steering group should be approached for information regarding workforce issues e.g. reporting on services now and forward look on issues.
• There is a meeting on 31st July at Don Valley House for Medical Director, Directors and CEO’s and a viewpoint from the providers at this meeting could be obtained.
• It is important that Healthwatch is included in the approach to ensure the community is engaged in the process.

The Chair informed members that:
• Will Cleary-Gray will liaise with Alexandra Norrish to ensure Chief Executives are contacted regarding discussions that she needs to progress.
• Will Cleary-Gray and Jackie Pederson will review the process regarding Overview and Scrutiny – testing out that in each place all organisations are included.
• Ensure timescales to approach Healthwatch are brought forward.
• The Acute Hospital Services Review should be an agenda item on the providers meeting on 31st July 2017.
• AO’s and CCG’s to consider if they require a similar meeting to the providers meeting that is happening on 31st July 2017.

The Chair thanked professor Chris Welsh for his presentation and his attendance at this meeting.

77/17  Finance Update
Louise Nunn presented the Finance Update paper for July 2017 on behalf of Jeremy Cook.

Louise asked Collaborative Partnership Board members to note the following key issues:

• The ACS financial refresh work is ongoing. The new financial modeling tool was reconciled to the Price Waterhouse Coopers (PWC) Model and identified understated savings by £6.5m.
• The actions agreed to take forward work on the Hyper Acute Stroke business case i.e. the project will be managed through the 3 groups – the finance group, commissioning/contracting group and the operational group.
- The ACS has been selected as one of six nationally to participate in the strategic estates planning and implementation project set up to assist ACS’s develop and implement their estates strategy. The key actions agreed were to undertake a prioritisation process, improve utilisation of estate, review options for the provision of CAMHS tier 4, consider estates implications for housing developments and surplus estates and rebuild options across South Yorkshire and Bassetlaw.

Will Cleary-Gray informed members that Yorkshire Ambulance Service (YAS) had made assumptions regarding flow in the Hyper Acute Stroke business case. ACS is working through the assumptions with YAS and these are being flagged to Collaborative Partnership Board members today as they could have implications on the business case.

The Collaborative Partnership Board noted the contents of the finance paper presented and thanked Louise Nunn for presenting the finance report.

### 78/17 Connection and Workforce Framework

The Chair welcomed Tim Gilpin, Peter Hall and Ben Chico to the meeting and invited them to give their presentation.

Peter Hall presented the information to the meeting.

Members were very supportive of this work area and noted:

- The impact on primary, community and social care that needs to be quantified and aligned within the strategy.
- The importance of changing behaviours.
- The voluntary sector and unpaid sector and how the people involved could be engaged. There are 47,000 volunteers in our area.
- Prevention is also key.
- The horizontal integration with back office functions must be considered.

Peter Hall added the draft report is out for review and comments and contributions are welcomed. A report will be brought to Collaborative Partnership Board members regarding strategic proposals.

The Chair thanked Tim Gilpin, Peter Hall and Ben Chico for their presentation and attendance at this meeting.

### 79/17 Development of a Single Accountability Framework

The Chair welcomed Mark Janvier to the meeting and invited him to present this report on behalf of Alison Knowles.

Mark Janvier identified:

- The developments made on external oversight where SYB ACS is represented on the national working group to design the new arrangements.
- The internal assurance arrangements which consisted of two elements: our operating model and the structure of the assurance framework.
- That SYB ACS needs to design the operating model and governance, to support assurance within the system.
- The tiered structure of the assurance framework.
Collaborative Partnership Board members were agreed that it is essential to get the outcome metrics right.

The Collaborative Partnership Board received the Update on Single Accountability Framework and noted this is work in progress.

**80/17 Commissioning Reform and Development of Accountable Care Partnerships**

Idris Griffiths was invited to present the paper on this subject (the presentation will be circulated to members).

The Collaborative Partnership Board noted the progress presented on the emerging model for accountable care in South Yorkshire and Bassetlaw based on:

- Collaboration rather than competition.
- Integration of commissioning and provision, both at ACS and in local place.
- An integrated ACS at STP level, underpinned with Accountable Care Partnerships (ACPs) in place, each with a single management structure across primary, community, mental health and acute care and (and possible social care and public health) ready to take a capitated budget for their population.

Members added:
- That good progress has been made across ‘place’ and it is good for communities to see a simpler mechanism.
- The voluntary sector/Healthwatch should be included as they have a wealth of experience that can be utilised.
- There is something for everyone to get everyone around the table which we can then test, this is a learning environment and if something is not right we can resolve it.

The Chair thanked Idris Griffiths for presenting this paper that was also accredited to Chris Edwards, Jackie Pederson, Maddy Ruff and Lesley Smith.

Collaborative Partnership Board members noted the plans for commissioning reform and the progress on ACP development in each of the five places.

**81/17 Summary Update to the Collaborative Partnership Board**

The SYB ACS Collaborative Partnership Board received and considered the summary update for the ACS workstreams and will use this information to inform local discussion.

**82/17 Any Other Business**

There was no other business brought before the meeting.

**83/17 Date and Time of Next Meeting**

Members were informed there will be no Collaborative Partnership Board meeting in August 2017.
The next meeting will take place on 8th September 2017 at 9.30am to 11.30am in the Boardroom at 722 Prince of Wales Road, Sheffield.
Report: Committees in Common

Presented by: Martin Havenhand, Chairman
Author(s): Anna Milanec, Director of Corporate Affairs/ Company Secretary

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B6 and B8
Corporate Risk Register: -

Purpose of this paper:
This paper presents the final documentation relating to the Working Together Partnership enhanced governance structure, referred to as ‘Committees in Common’.

Summary of Key Points:
- All partners in the WTP have agreed to established their own board committee which will become one of seven committees, meeting in common with the remaining six.
- An overall Joint Working Agreement has also been considered, with each of the contributory Trusts being asked to approve.

Board action required:
The Board is asked to approve the documents appended at appendix A and appendix B.
1.0 Introduction

1.1 This paper presents the final documentation relating to the Working Together Partnership enhanced governance structure, referred to as ‘Committees in Common’.

2.0 Committees in Common structure

2.1 The seven WTP Trusts have been considering the Committees in Common structure for several months via board seminars and at a previous board meeting. The structure has also been discussed at various WTP forums, and its establishment has been aided with the support of legal advice.

2.2 The documentation comprises:

- Joint Working Agreement between the parties (appendix A); and
- The Trust’s Terms of Reference for its independent Board Committee (‘Rotherham CiC’) to meet in common with those of other Trusts in the Partnership (appendix B).

2.3 The Exit Plan referred to in Section 6 of the proposed Joint Working Agreement (‘the Agreement’) (appendix A) relating to the exit requirements for Trusts, has not yet been defined. The Agreement states that this will be developed within three months of the date of the said Agreement, therefore, meaning that if the Agreement is agreed, parties would enter into this agreement before these terms are known. In addition, section 7.2.2. states that an existing Trust may exit subject to the terms of the exit plan (which has not yet been agreed).

2.4 However, this has now been discussed and the Trust Chairs have agreed that the documentation should be approved by Trust Boards in its current format.

Anna Milanec,
Director of Corporate Affairs/Company Secretary
September 2017
Appendix A

DATED: 2017

(1) BARNSLEY NHS FOUNDATION TRUST
(2) CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
(3) DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST
(4) THE MID YORKSHIRE HOSPITALS NHS TRUST
(5) THE ROTHERHAM NHS FOUNDATION TRUST
(6) SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST
(7) SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

______________________________

JOINT WORKING AGREEMENT

______________________________
1. **Introduction**

1.1 In this joint working agreement, the following words bear the following meanings:

<table>
<thead>
<tr>
<th><strong>Confidential Information</strong></th>
<th>all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this JWA;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competition Sensitive Information</strong></td>
<td>means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;</td>
</tr>
<tr>
<td><strong>Dispute</strong></td>
<td>any dispute arising between two or more of the Trusts in connection with this Joint Working Agreement or their respective rights and obligations under it;</td>
</tr>
<tr>
<td><strong>Meeting Lead</strong></td>
<td>the WTP CiC Member nominated (from time to time) in accordance with paragraph 6.4 of the Terms of Reference, to preside over and run the WTP CiC meetings when they meet in common;</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>a person nominated as a member of a WTP CiC in accordance with their Trust’s Terms of Reference and “Members” shall be interpreted accordingly;</td>
</tr>
<tr>
<td><strong>“Joint Working Agreement” or “JWA”</strong></td>
<td>this agreement signed by each of the Trusts in relation to their joint working and the operation of the WTP CiCs;</td>
</tr>
<tr>
<td><strong>Terms of Reference</strong></td>
<td>the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices to this Joint Working Agreement;</td>
</tr>
<tr>
<td><strong>Trusts</strong></td>
<td>Barnsley NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children’s NHS Foundation Trust, Sheffield Teaching Hospitals NHS Trust and “Trust” shall be interpreted</td>
</tr>
</tbody>
</table>
Appendix A

| WTP CiCs | the committees established by each of the Trusts to work alongside the committees established by the other Trusts and “WTP CiC” shall be interpreted accordingly. |

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other WTP CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each WTP CiC will be different.

2. **Background**

2.1 Since 2013, the Trusts have been working together as an innovative partnership (the Working Together Partnership) and the Working Together Partnership became an Acute Care Collaboration Vanguard in 2015.

2.2 The Working Together Partnership’s stated aims are to strengthen each of the Trusts by sharing collective expertise and knowledge to:

   2.2.1 improve quality, safety and the patient experience;
   2.2.2 deliver safe and sustainable new models of care;
   2.2.3 deliver equity of access and improve activity; and
   2.2.4 make collective efficiencies where the potential exists.

2.3 In July 2016 the Boards of the Trusts, as part of the Working Together Partnership, confirmed the creation of the Acute Federation. It was agreed that further phases for changes to the governance structure would develop to enhance the delivery of the new models of care as the service change options became clearer.

2.4 In light of the above, the Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the existing legislation, enables “group” and common decision making structures; the WTP CiCs.

2.5 More specifically the WTP CiCs will facilitate the Trusts’ work in the following four key areas:

   2.5.1 **Informatics** - to identify the potential areas where collaboration on informatics systems, services or infrastructure between the Trusts could take place;
2.5.2 **Sharing and adopting good practices** - to enable the adoption of good practice and learning across the Trusts, including the provision of integrated and shared corporate services;

2.5.3 **Sustainable Care Quality** - to improve the provision of sustainable quality care between trusts; and

2.5.4 **Sustainable Service Configuration** - to explore where quality and safety benefits could be achieved from further collaborative working.

2.6 The Trusts will remain as seven separate legal entities with their own accountabilities and responsibilities. For avoidance of doubt there is no intention that the governance structure outlined in this Joint Working Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3. **Principles of working**

3.1 The Trusts have agreed to adopt this Joint Working Agreement dated [INSERT DATE] and agree to operate the WTP CiCs in line with the terms of this JWA, including the following principles (the “**Principles of Working**”):

3.1.1 through collaboration with each other aspiring, for the benefit of our patients, to be one of the most innovative, safe, caring, responsive, effective, well led and efficient health and care systems by 2020;

3.1.2 making the starting point for everything the Trusts do “can this be done better, safer, more economically for our patients if we work with our partners in a different way?”;

3.1.3 move at pace in examining all activities on a “bottom up” basis, across the Trusts, engaging clinical and non-clinical teams to adopt innovative approaches and best practice;

3.1.4 challenge themselves and embrace change where it benefits its patients or the health care system as a whole. Status quo is not an option if we are to do the right thing for patients on a sustainable basis;

3.1.5 establish a governance model which facilitates this approach. Structure will not be a barrier to innovative change while recognising the statutory responsibilities of all seven individual Trust Board of Directors;

3.1.6 models of cost/benefit equalisation will be a key ingredient of the partnership activity to ensure financial loss or gain for any individual Trust is not a barrier to beneficial system change/progress;

3.1.7 seek support from commissioners to ensure changes are achieved at pace in order to gain maximum benefits for patients and system stability;
3.1.8 collaborate and co-operate. Establish and adhere to the governance structure set out in the Terms of Reference to ensure that activities are delivered and actions taken as required;

3.1.9 be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference;

3.1.10 be open. Communicate openly about major concerns, issues or opportunities relating to the joint working subject always to appropriate treatment of commercially sensitive information and competition law compliance;

3.1.11 adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation;

3.1.12 act in a timely manner. Recognise the time-critical nature of the joint working and respond accordingly to requests for support;

3.1.13 manage stakeholders effectively; and

3.1.14 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the requirements and responsibilities set out in this Joint Working Agreement and the Terms of Reference.

4. Process of working together

4.1 The WTP CiCs shall meet together in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-7).

4.2 The WTP CiCs shall work collaboratively with each other in relation to the committees in common model.

4.3 Each WTP CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of References, and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any WTP CiC or its duty to act in the best interests of its Trust, each WTP CiCs shall seek to reach agreement with the other WTP CiCs and take decisions in consensus, in light of its aims and Principles of Working set out in clauses 2 and 3 above.

4.4 When the WTP CiCs meet in common, the Meeting Lead shall preside over and run the meeting on a rotational basis for a period of six months.
5. **Future Involvement and Addition of Parties**

5.1 Subject to complying with all applicable law, and the Trusts’ unanimous agreement, third parties may become parties to this Joint Working Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Joint Working Agreement.

6. **Exit Plan**

6.1 Within three (3) months of the date of this JWA the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

   6.1.1 termination of this JWA;
   
   6.1.2 a Trust exercising its rights under clause 7.1 below; or
   
   6.1.3 the Meeting Lead and the WTP CiC Chairs varying the JWA under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this JWA at Appendix 8 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this JWA.

7. **Termination**

7.1 If any Trust wishes to revoke the delegation of functions to the relevant committee and exit this JWA ("Exiting Trust"), then the Exiting Trust shall, prior to such revocation and exit:

   7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts’ Chairs of their intention to do so; and
   
   7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts’ Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

   7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or
   
   7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exiting the JWA,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 8) exit this JWA.
7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its WTP CiC and exits this JWA then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this JWA; or

7.3.2 Amend and replace this JWA with a revised joint working agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8. **Information Sharing and Competition Law**

8.1 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the provision of the JWA in an honest, open and timely manner.

8.2 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law.

8.3 The Trusts will seek to agree a protocol to manage the sharing of information in accordance with competition law requirements, within three (3) months of the date of this JWA. Once agreed, this protocol shall be inserted into this JWA at Appendix 9 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this JWA.

9. **Conflicts of Interest**

Members of each of the WTP CiCs shall ensure that Members of the other WTP CiCs are aware of any conflict of interest applicable to them, which has any relevance to the work of the WTP CiCs.

10. **Dispute Resolution**

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Principles of Working set out in clause 3 above.

10.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to any matter in this JWA, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the WTP CiC Chairs the appropriate course of action to take.

10.4 If the Meeting Lead and the WTP CiC Chairs reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the
decision by written notice. Any decision of the Meeting Lead and the WTP CiC Chairs will be final and binding on the Trusts once it has been ratified by the Trusts’ Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the WTP CiC Chairs, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the WTP CiC Chairs, may determine whatever action they believes is necessary including the following:

10.5.1 If the Meeting Lead and the WTP CiC Chairs cannot resolve a Dispute, the Meeting Lead may select an independent facilitator to assist with resolving the Dispute; and

10.5.1.1 the independent facilitator shall:

a) be provided with any information he or she requests about the Dispute;

b) assist the Meeting Lead and WTP CiC Chairs to work towards a consensus decision in respect of the Dispute;

c) regulate his or her own procedure and, subject to the terms of this JWA, the procedure of the Meeting Lead and WTP CiC Chairs at such discussions;

d) determine the number of facilitated discussions, provided that there will be not less than three and not more than seven facilitated discussions, which must take place within 20 Working Days of the independent facilitator being appointed; and

e) have its costs and disbursements met by the Trusts equally.

10.6 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only after such further consideration again fails to resolve the Dispute, the Meeting Lead and WTP CiC Chairs may decide to recommend their Trust’s Board of Directors to:

10.6.1 terminate the JWA;

10.6.2 vary the JWA (which may include a re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11. Variation

No variation of this JWA shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).
12. **Counterparts**

12.1 This JWA may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this JWA, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this JWA transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13. **Governing law and jurisdiction**

This JWA shall be governed by and construed in accordance with English law.
THIS JOINT WORKING AGREEMENT is executed on the date stated above by

For and on behalf of Barnsley NHS Foundation Trust

For and on behalf of Chesterfield Royal Hospital NHS Foundation Trust

For and on behalf of Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

For and on behalf of The Mid Yorkshire Hospitals NHS Trust

For and on behalf of The Rotherham NHS Foundation Trust

For and on behalf of Sheffield Children’s NHS Foundation Trust

For and on behalf of Sheffield Teaching Hospitals NHS Foundation Trust
APPENDIX 1

[Insert Terms of Reference for the Barnsley NHS Foundation Trust CiC]
APPENDIX 2

[Insert Terms of Reference for the Chesterfield Royal Hospital NHS Foundation Trust CIC]
APPENDIX 3

[Insert Terms of Reference for the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust CiC]
APPENDIX 4

[Insert Terms of Reference for The Mid Yorkshire Hospitals NHS Trust CiC]
APPENDIX 5

[Insert Terms of Reference for The Rotherham NHS Foundation Trust CiC]
APPENDIX 6

[Insert Terms of Reference for the Sheffield Children’s NHS Foundation Trust CiC]
APPENDIX 7

[Insert Terms of Reference for the Sheffield Teaching Hospitals NHS Foundation Trust CiC]
Appendix 8

Exit Plan

[to be inserted once agreed]
Appendix 9

Information Sharing protocol
[to be inserted once agreed]
THE ROTHERHAM NHS FOUNDATION TRUST

TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER TRUSTS
## TERMS OF REFERENCE

### 1 Introduction

1.1 In this terms of reference, the following words bear the following meanings:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Federation</strong></td>
<td>the federation formed by the Trusts to provide strategic leadership and oversight of the delivery of the Working Together Partnership;</td>
</tr>
<tr>
<td><strong>“Joint Working Agreement” or “JWA”</strong></td>
<td>the agreement signed by each of the Trusts in relation to their joint working and the operation of the Rotherham CiC together with the WTP CiCs;</td>
</tr>
<tr>
<td><strong>Meeting Lead</strong></td>
<td>the WTP CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the WTP CiC meetings when they meet in common;</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>a person nominated as a member of a WTP CiC in accordance with their Trust’s Terms of Reference, and Members shall be interpreted accordingly;</td>
</tr>
<tr>
<td><strong>Rotherham CiC</strong></td>
<td>the committee established by The Rotherham NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other WTP CiCs in accordance with these Terms of Reference;</td>
</tr>
<tr>
<td><strong>Rotherham CiC Chair</strong></td>
<td>the Rotherham CiC Member nominated (in accordance with paragraph 7.5 of these terms of reference) to chair the Rotherham CiC meetings;</td>
</tr>
<tr>
<td><strong>STP</strong></td>
<td>South Yorkshire &amp; Bassetlaw Sustainability and Transformation Plan;</td>
</tr>
<tr>
<td><strong>The Rotherham NHS Foundation Trust</strong></td>
<td>The Rotherham NHS Foundation Trust, Rotherham General Hospital, Moorgate Road, Oakwood, Rotherham, South Yorkshire S60 2UD;</td>
</tr>
<tr>
<td><strong>Trusts</strong></td>
<td>Barnsley NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children’s NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and “Trust” shall be interpreted accordingly;</td>
</tr>
<tr>
<td><strong>Working Day</strong></td>
<td>a day other than a Saturday, Sunday or public holiday in England;</td>
</tr>
</tbody>
</table>
The Rotherham NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts to implement change.

Each Trust has agreed to establish a committee which shall work in common with the other WTP CiCs, but which will each take its decisions independently on behalf of its own Trust.

Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each WTP CiC will be different.

Each Trust has entered into the Joint Working Agreement on [DATE TO BE INSERTED] and agrees to operate its WTP CiC in accordance with the Joint Working Agreement.

The aims and objectives of the Rotherham CiC are to work with the other WTP CiCs to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of the Acute Federation and its workstreams;

2.1.2 set the strategic goals for the Acute Federation, defining its ongoing role and scope ensuring recommendations are provided to Trusts’ Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;
2.1.5 ensure all Managed Clinical Networks or other collaborative forums have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Reference Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the joint strategic STP Boards in South Yorkshire and Bassetlaw; West Yorkshire and Derbyshire;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review and approve the Terms of Reference for the Acute Federation on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The Rotherham NHS Foundation Trust’s board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Rotherham CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Rotherham CiC.

3.2 The Rotherham CiC shall work cooperatively with the other WTP CiCs and in accordance with the terms of the Joint Working Agreement.

3.3 The Rotherham CiC is a committee of The Rotherham NHS Foundation Trust’s board of directors and therefore can only make decisions binding The Rotherham NHS Foundation Trust. None of the Trusts other than The Rotherham NHS Foundation Trust can be bound by a decision taken by Rotherham CiC.
4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in paragraph 8.8.3 of The Rotherham NHS Foundation Trust’s Constitution.

4.2 The Rotherham CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the Rotherham CiC in paragraph 4 of these Terms of Reference shall be retained by The Rotherham NHS Foundation Trust’s Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of The Rotherham NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Rotherham CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to The Rotherham NHS Foundation Trust’s Board for inclusion on the private agenda of The Rotherham NHS Foundation Trust’s next Board meeting in order that The Rotherham NHS Foundation Trust’s Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Rotherham CiC shall send the minutes of Rotherham CiC meetings to The Rotherham NHS Foundation Trust’s Board, on a monthly basis, for inclusion on the private agenda of The Rotherham NHS Foundation Trust’s Board meeting.

6.3 Rotherham CiC shall provide such reports and communications briefings as requested by The Rotherham NHS Foundation Trust’s Board for inclusion on the private agenda of The Rotherham NHS Foundation Trust’s Board meeting.

7 Membership

7.1 The Rotherham CiC shall be constituted of directors of The Rotherham NHS Foundation Trust. Namely:

7.1.1 The Rotherham NHS Foundation Trust’s Chair; and

7.1.2 The Rotherham NHS Foundation Trust’s Chief Executive,
and each shall be referred to as a “Member”.

7.2 Each Rotherham CiC Member shall nominate a deputy to attend Rotherham CiC meetings on their behalf when necessary (“Nominated Deputy”).

7.3 The Nominated Deputy for The Rotherham NHS Foundation Trust’s Chair shall be a Non-Executive Director of The Rotherham NHS Foundation Trust and the Nominated Deputy for The Rotherham NHS Foundation Trust’s Chief Executive shall be an Executive Director of The Rotherham NHS Foundation Trust.

7.4 In the absence of the Rotherham CiC Chair Member and/or the Rotherham CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Rotherham CiC’s meetings;
7.4.2 be counted towards the quorum of a meeting of Rotherham CiC’s; and
7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a Rotherham CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to “Members”.

7.5 The chair of the Rotherham CiC shall be nominated by the Rotherham CiC. In the absence of the Rotherham CiC Chair the Nominated Deputy of The Rotherham NHS Foundation Trust’s Chair shall chair the meeting.

7.6 When the WTP CiCs meet in common, one person nominated from the Members of the WTP CiCs shall be the Meeting Lead and preside over and run the meetings on a rotational basis for a period of six months.

8 Non-voting attendees

8.1 The Members of the other WTP CiCs shall have the right to attend the meetings of Rotherham CiC.

8.2 The Meeting Lead’s Trust Corporate Secretary shall have the right to attend the meetings of Rotherham CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the WTP CiCs.

8.3 The Working Together Partnership Medical Director, Programme Director and Clinical Reference Group Chair shall have the right to attend the meetings of Rotherham CiC.

8.4 In the interests of wider collaborative working, the Chair and Chief Executive of the following organisations:

8.4.1 Sheffield Health and Social Care NHS FT;
8.4.2 Rotherham, Doncaster and South Humber NHS FT;
8.4.3 South West Yorkshire Partnership NHS Foundation Trust; and
8.4.4 Nottinghamshire Healthcare NHS Foundation Trust,

shall, in accordance with paragraph 8.5, be invited to attend a Rotherham CiC meeting on a quarterly basis or on a frequency otherwise agreed.

8.5 Without prejudice to paragraphs 8.1 to 8.4 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the WTP CiCs’ meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the WTP CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.6 The attendees detailed in paragraphs 8.1 to 8.5 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Rotherham CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, Rotherham CiC meetings shall take place monthly.

9.2 Any Trust CiC Chair may request an extraordinary meeting of the WTP CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the Working Together Partnership Programme Office shall give five (5) Working Days’ notice to the Trusts.

9.3 Meetings of the Rotherham CiC shall be held in private.

9.4 Matters to be dealt with at the meetings of the Rotherham CiC shall be confidential to the Rotherham CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of The Rotherham NHS Foundation Trust Board.

10 Quorum and Voting

10.1 Members of the Rotherham CiC have a responsibility for the operation of the Rotherham CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Rotherham CiC shall have one vote. The Rotherham CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be two (2) Members.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
11 Conflicts of Interest

11.1 Members of the Rotherham CiC shall comply with the provisions on conflicts of interest contained in The Rotherham NHS Foundation Trust Constitution/Standing Orders. For the avoidance of doubt, reference to conflicts of interest in The Rotherham NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Rotherham CiC.

11.2 All Members of the Rotherham CiC shall declare any new interest at the beginning of any Rotherham CiC meeting and at any point during a Rotherham CiC meeting if relevant.

12 Attendance at meetings

12.1 The Rotherham NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, Rotherham CiC Members (or their Nominated Deputy) shall attend Rotherham CiC meetings (in person) and fully participate in all Rotherham CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Rotherham CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the Rotherham CiC will be provided by the Working Together Partnership Programme Management Office (or such other person as the Trusts may agree in writing). The Working Together Partnership Programme Management Office will:

13.1.1 draw up an annual schedule of WTP CiC meeting dates and circulate it to the WTP CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to WTP CiC meetings; and

13.1.3 take minutes of each Rotherham CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Rotherham CiC meeting.

13.2 The agenda for the Rotherham CiC meetings shall be determined by the Working Together Partnership Programme Director and agreed by the Meeting Lead prior to circulation.
13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the Working Together Partnership Programme Management Office to agree such within five (5) Working Days of receipt.
APPENDIX A – DECISIONS OF THE ROTHERHAM CiC

The Board of each Trust within the Working Together Partnership remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to The Rotherham NHS Foundation Trust’s Scheme of Delegation, the matters or type of matters that are fully delegated to the Rotherham CiC to decide are set out in the table below.

If it is intended that the WTP CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Rotherham CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Rotherham CiC meeting with a view to Rotherham CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by The Rotherham NHS Foundation Trust’s Board). Any proposals discussed at the Rotherham CiC meeting outside of these parameters would come back before The Rotherham NHS Foundation Trust’s Board.

References in the table below to the “Services” refer to the services that form part of the joint working between the Trusts and may include both back office and clinical services.

<table>
<thead>
<tr>
<th>Decisions delegated to Rotherham CiC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providing overall strategic oversight and direction to the development of the Working Together Partnership programme ensuring alignment of all Trusts to the vision and strategy;</td>
</tr>
<tr>
<td>2. Promoting and encouraging commitment to the Key Principles;</td>
</tr>
<tr>
<td>3. Seeking to determine or resolve any matter within the remit of the Rotherham CiC referred to it by the WTP Programme Office or any individual Trust;</td>
</tr>
<tr>
<td>4. Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the risks associated in terms of the impact to the WTP Partnership Programme and recommending remedial and mitigating actions across the system;</td>
</tr>
<tr>
<td>5. Formulating, agreeing and implementing strategies for delivery of the WTP Partnership Programme;</td>
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<tr>
<td>Decisions delegated to Rotherham CiC</td>
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<td>------------------------------------</td>
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<tr>
<td><strong>6.</strong> In relation to the Services preparing business cases;</td>
</tr>
<tr>
<td><strong>7.</strong> Provision of staffing and support and sharing of staffing information in relation to the Services;</td>
</tr>
<tr>
<td><strong>8.</strong> Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to:</td>
</tr>
<tr>
<td>a. provision of financial information;</td>
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<tr>
<td>b. communications with staff and the public and other wider engagement with stakeholders;</td>
</tr>
<tr>
<td>c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England and/or NHS Improvement;</td>
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<tr>
<td>d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows;</td>
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<tr>
<td>e. support in relation to any competition assessment;</td>
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<tr>
<td>f. provision of staffing support; and</td>
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<tr>
<td>g. provision of other support.</td>
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<tr>
<td><strong>9.</strong> Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to:</td>
</tr>
<tr>
<td>a. redesign of clinical rotas;</td>
</tr>
<tr>
<td>b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and</td>
</tr>
<tr>
<td>c. developing and improving information recording and information flows (clinical or otherwise).</td>
</tr>
<tr>
<td><strong>10.</strong> Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to:</td>
</tr>
<tr>
<td>a. preparing joint venture documentation and ancillary agreements for final signature;</td>
</tr>
<tr>
<td>b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts;</td>
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<tr>
<td>c. carrying out an analysis of the implications of TUPE on the joint arrangements;</td>
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<tr>
<td>d. engaging staff and providing such information as is necessary to meet each employer’s statutory requirements;</td>
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<tr>
<td>e. undertaking soft market testing and managing procurement exercises;</td>
</tr>
<tr>
<td>f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and</td>
</tr>
<tr>
<td>Decisions delegated to Rotherham CiC</td>
</tr>
<tr>
<td>-------------------------------------</td>
</tr>
<tr>
<td>g. amendments to joint venture agreements for the Services.</td>
</tr>
<tr>
<td>11. Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;</td>
</tr>
<tr>
<td>12. Reviewing and approving the Terms of Reference and Joint Working Agreement of the CiC on an annual basis.</td>
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Report: South Yorkshire and Bassetlaw Accountable Care System, Memorandum of Understanding

Presented by: Lisa Reid, Head of Governance
Author(s): Anna Milanec, Director of Corporate Affairs/ Company Secretary

Strategic Objective:
- Patients: Excellence in healthcare
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations
- Partners: Securing the future together

Regulatory relevance:
- NHSI: Licence Condition FT4 / Single Oversight Framework
- CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
- BAF: B6 and B8
- Corporate Risk Register: 3520, 3908, 5084

Purpose of this paper:
This paper provides details of the Trust's agreed relationship with partners as part of the South Yorkshire and Bassetlaw Accountable Care System (ACS) and how this has been followed by signing up to a regional Memorandum of Understanding (MOU), and subsequently to a MOU between the ACS, NHSE and NHSI.

Summary of Key Points:
- Progress being made in the South Yorkshire and Bassetlaw Accountable Care System (ACS), with support from the Place Plans and Accountable Care Partnerships (ACPs).
- The ACS is now ready to enter into agreements with NHSE and NHSI

Board action required:
For noting
1.0 Introduction

1.1 As described in Next Steps on the NHS Five Year Forward View, a small number of STPs were named as England’s first Accountable Care Systems (ACSs), operating in ‘shadow’ form in 2017/18, becoming ‘full’ ACSs from 2018/19 if the right progress has been made. The Trust is part of the South Yorkshire and Bassetlaw Accountable Care System (ACS).

2.0 Regional ACS Memorandum of Understanding

2.1 The organisation recently entered into a regional MOU, which set out the partners’ shared commitment to work together on issues which are considered important for improving the health and care of the local populations of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

2.2 Each of these locations have developed Accountable Care Partnerships (ACPs) to deliver the ambitions set out in their Place Plans. These are working in shadow form at the moment, and will be legally constituted by 1 April 2018.

2.3 The five ACPs have brought together health and care services to create an integrated system in each Place. Each Place is exploring new ways of contracting and allocating resources to its ACP.

2.4 The five ACPs are now connecting between the five Places and with horizontally integrated networks of hospital-based care, and are creating the overall ACS for South Yorkshire and Bassetlaw.

2.5 The ACS collaborative approach is focused on prevention, integration, physical and mental health, and addressing the wider determinants of health, which include:

- Employment, opportunity and business
- Adult and social care, enabling independence
- Raising levels of education to improve opportunity
- Safe, clean and green environment, and
- Life chances for all.

2.6 Parties to the regional ACS MOU include health care commissioners, providers, regulators, with local authority partners and provider partners.

2.7 System objectives are summarised as:

- Provision of better quality care and health services
- Wider variety of healthy living schemes, active health networks and greater collaboration across the public sector, and
- Provision of high quality and efficient services, with a flexible workforce and services

2.8 Transformation work streams include:

- Urgent and emergency care
- Cancer
- Healthy lives, living well and prevention
- Primary care
- Mental health
- Elective care and diagnostics, and
- Maternity and children's/
2.6 Inextricably linked are enabler work streams, which include workforce, digital and IT, Carter, estates and shared services, finance, communications and engagement.

2.7 The South Yorkshire and Bassetlaw ACS is now entering into an MOU with NHS England and NHS Improvement.

3.0 ACS Memorandum of Understanding with NHSE and NHSI

3.1 In order to further develop the frameworks within which the regional partners will be working and held to account, the South Yorkshire and Bassetlaw ACS is now entering into an MOU with NHS England and NHS Improvement.

3.2 As there is no blueprint for the extent of this integration, the national bodies will work alongside the ACS to push existing boundaries, rapidly innovate, evaluate and develop the framework for the remainder of the NHS.

Anna Milanec,
Director of Corporate Affairs/Company Secretary
September 2017
Health and Care
Working Together

South Yorkshire & Bassetlaw
Accountable Care System

Memorandum of Understanding
‘Agreement’

June 2017
<table>
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<tr>
<th><strong>Title</strong></th>
<th>Memorandum of Understanding for South Yorkshire and Bassetlaw Sustainability and Transformation Partnership</th>
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<tr>
<td><strong>Drafting coordinator</strong></td>
<td>Will Cleary-Gray</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>SYB Collaborative Partnership Board Membership, Place Partnership and Boards, statutory organisation Boards, Governing Bodies, Councils, NHS England, NHS Improvement and the ALBs and the Department of Health</td>
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<tr>
<td><strong>Version</strong></td>
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<td><strong>Created Date</strong></td>
<td>10 April 2017</td>
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<tr>
<td><strong>Document Status</strong></td>
<td>Final Draft for adoption by local governance</td>
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<tr>
<td><strong>To be read in conjunction with</strong></td>
<td>Health and Care Plan Submission, November 2016, 5 Place Plans, individual statutory organisational plans and SYFV Delivery Plan – next steps</td>
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<th>Version</th>
<th>Coordinating Author (s)</th>
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<td>Will Cleary-Gray</td>
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<td>Will Cleary-Gray</td>
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<td>Will Cleary-Gray</td>
<td>Updated following feedback from Boards, Governing Bodies and Councils</td>
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<tr>
<td>23rd June</td>
<td>0.4</td>
<td>Will Cleary-Gray</td>
<td>Initial feedback from CPB members</td>
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**Approval by:**
Foreword

This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. It is not a plan or a legal contract. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

It does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. This document recognises the complexity of how health and care organisations currently work and interact together to provide the best possible care and services. It is also mindful of how health and care organisations are coming together to form partnerships locally in place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. At the same time, some of those same organisations have formed partnerships and are coming together across South Yorkshire and Bassetlaw to plan and commission strategically to ensure safe, sustainable and equitable acute services. In short, we are seeing increased collaboration, joint planning and integration of services that are focused entirely on bringing the greatest benefits to our population.

It is a complex picture and one which we must work through together as we continue to focus on what matters – the people in the populations we serve. This means constantly reviewing our approach, together with our staff, patients and citizens. We will also continue to build trust between us, working through what is best for our populations while using best practice where it exists and national guidance and support where we need it.

This document summarises and sets out our shared commitment to continue to work together on improving health and care for the people of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield and collectively South Yorkshire and Bassetlaw. We still have much to work through and our plans and our approaches to delivering them continue to evolve.

This is our best assessment for 2017-19 on how we will work together, what we will work on and what we need to accelerate our vision and plans – the ‘Give’ and ‘Get’ which lies at the core of this MoU.

As we are in transition it is helpful to clarify how we are using terminology and acronyms for the purposes of this document. Sustainability and Transformation Plan (STP), Accountable Care System (ACS) and South Yorkshire and Bassetlaw Health and Care Partnership (SYB) are used throughout and they refer to the same thing – our SYB Partnership and our collaborative approach.

Andrew Cash, ACS Lead
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1. Introduction and context

1.1. This document has been developed with South Yorkshire and Bassetlaw Health and Care partners. **It is not a plan** or a **legal contract**. We have already published our Plans across the five local Places and system in South Yorkshire and Bassetlaw. At the same time, each of our individual organisations has contracts in place.

1.2. It does not replace the **legal framework or responsibilities of our statutory organisations** but instead sits alongside the framework to complement and enhance it, **setting out the framework** within which our organisations will come together to establish how we will develop as an **Accountable Care System**.

1.3. South Yorkshire and Bassetlaw has **five strong health and social care communities** of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield which have a long history of **working together** in each local Place and across South Yorkshire and Bassetlaw (SYB) to achieve positive change and improvements for local people.

1.4. The links between **poverty** and **ill health** are well established and are the driving force behind our joint working. Creating **jobs**, ensuring availability of affordable, good **quality housing** and targeting resources towards areas of **greatest need and reducing inequalities** are all important to **reduce poverty** and **improve our health and wellbeing**.

1.5. Our collective and collaborative approach is increasingly focused therefore on **prevention**, **integration**, **physical and mental health** and crucially, **co-production** with **citizens and communities**; addressing the **wider determinants of health together**. These are inextricably linked and include:

- Employment, opportunity and business
- Adult and child health and social care, enabling independence
- Raising levels of **education and skills** to improve opportunity
- Safe, clean and green **environment**
- **Life chances** for all

1.6. Each health and social care organisation in each Place **already has plans** which have been developed in partnership and in some cases, for example the **Better Care Fund Plan**, these plans are **jointly owned** between health and social care.

1.7. There is a shared view that in order to transform our services to the degree required to achieve **excellent and sustainable services** in the future, we need to have a single shared vision and single shared plan both for each Place and for South Yorkshire and Bassetlaw. For this reason, **leaders** from across health and social care in each Place have come together to develop a **single shared vision** and **single shared plan** which has resulted in **Place Plans** and the SYB Plan.

1.8. South Yorkshire and Bassetlaw is therefore in a good position with a single shared vision and plan in each Place. This is made possible by the commitment and significant contributions of each constituent organisation.

1.9. This puts each of our localities, and system as a whole, in a **strong position** to develop and realise an ambitious set of health and social care services for our patients and service users; ensuring the best possible quality of care within available resources.

1.10. In developing a joint vision and plans in each Place, we intend to maximise the value of our collective action and, through our joined up efforts, accelerate our ability to transform the way we deliver services. Our **Plans** are not starting from scratch or replacing individual partners’ plans- they build on existing plans, taking a common view and identifying areas where it makes sense for us to work together and collaborate.
1.11. Central to these ambitions is developing different relationships with each other in Place, across the system and with those that assure and regulate our health services. This will enable us to focus on integrating health and social care services and ensuring safe, sustainable and equitable hospital services for everyone.

1.12. We are committed to ensuring citizens and staff have the opportunity to be involved in conversations to help shape the direction of travel in the ACS and in Place. This ranges from their role in wellness, prevention and self-care; identifying what's important to them in the delivery of services; as well as more specific consultation about service changes; and on the ongoing transparency and opportunity for them to hold us to account for delivery.

1.13. A key test of our new relationships will be the extent to which we adopt, as a first principle, an altruistic approach to each other as partners ‘working as one’. How we respond as partners in times of need will be crucial and we must always put the needs of individuals, patients and the public first.

1.14. This document sets out how we propose to organise ourselves to provide the best health and care, ensuring that decisions are always taken in the interest of the patients we serve. It allows us to push even further beyond organisational need and allows us to build on working together in each Place and working together across SYB - to take collective strategic decisions across the whole of South Yorkshire and Bassetlaw to lift the standard of care no matter where people live or the organisation charged with planning or delivering care.

1.15. South Yorkshire and Bassetlaw set out its strategic ambition and priorities to improve health and wellbeing for all local populations in the Health and Care plan published in November 2016, together with how this will be implemented in each of the five Place Plans across Bassetlaw, Barnsley, Doncaster, Rotherham and Sheffield.

1.16. Following publication of the Next Steps in the Five Year Forward View, South Yorkshire and Bassetlaw has been confirmed as a high performing system and named as one of the eight Accountable Care Systems nationally. This means being supported centrally with additional funding, capacity and capability to be able to have more local control over health and care resources and in the delivery of transformational changes to services for people of South Yorkshire and Bassetlaw. This ability to have more local control is mainly reflective of the potential devolved responsibilities from health, its regulatory and assurance framework and health funding and resources.

1.17. This ‘Agreement’ sets out the framework within which our partner organisations, including NHS England and NHS Improvement will come together ‘working as one’, in 2017/18 to establish how South Yorkshire and Bassetlaw will develop as an Accountable Care System. We will agree together the delegated powers and new relationships we adopt between partner organisations, health regulators and health assurers to better achieve ambitions set out in the Plan and five Place plans.

1.18. The MoU sets out the approach to collaborative working and ambition to work as a shadow Accountable Care System in 2017/18, together with key milestones to move to a full ACS in 2018/19. SYB will engage with NHS England centrally, the Department of Health and the national Arm’s Length Bodies (ALBs) to work through in 2017/18 how and what devolved NHS powers it will receive in 2018 as an Accountable Care System and which will be reflected in and subject to separate and specific agreements both with NHS England and local statutory organisations. Throughout this process we will be mindful of the legal duties placed on each partner organisation.

1.19. This ‘Agreement’ should be read in conjunction with the Plan, published in November 2016 and the five local Place plans across South Yorkshire and Bassetlaw. It should be viewed as a framework to enable collaborative working, secure central funding and support new
relationships with Arms Length Bodies (ALBs) in the pursuit of becoming an ACS to better deliver improved health and care for the population of South Yorkshire and Bassetlaw.

1.20. This ‘Agreement’ recognises the importance of integration of health and social care in each Place and that this will be an important factor in working through how the emerging Accountable Care Partnerships - which are being developed in each Place across partners and complement the ACS - develop to deliver improved care.

2. Parties to and partners in the Agreement

2.1. In developing this Agreement consideration has been given to the different relationships with constituent member organisations within the SYB ACS and the different relationship that organisations may wish to have with it. There are many partners working together - NHS and non NHS including local authorities and the voluntary sector each have respective governance, accountabilities and in many cases regulation responsibilities.

2.2. It is accepted that not all partners would want to be subject to many aspects of this agreement or indeed it would not be appropriate. NHS England and NHS Improvement have assisted SYB to establish clarity on which organisations should be Parties to and which might be Partners in this Agreement in context of NHS governance, accountability, regulation and assurance. For clarity, collectively, Parties to and Partners in are all members of the SYB Collaborative and its associated Partnership Board.

2.3. STP geographies were, in the large part, nationally defined. Core and associate partner terminology has been established over the course of developing the Plan to describe different partners and to support a wide and diverse partnership and to enable cross geographical boundary relationships and working.

2.3.1. For the purposes of this MoU core partners (‘Parties to’ the MoU) are NHS partners who have the majority relationships (patient flows and contracts) within and across SYB while Associate partners (‘Partners in’ the MoU) have majority relationships (patient flows and contracts) as core members of neighboring STPs, and relationships in SYB generally confined to a Place or Accountable Care Partnership (ACP). Associate partners are also likely to be subject to collaborative agreements in neighboring STPs or local ACP and receive support consistent with respective STPs. For clarity, collectively, ‘Parties to’ and ‘Partners in’ are all members of the SYB Collaborative and its associated Partnership Board.

2.3.1. In the case of Chesterfield Royal Hospital NHS Foundation Trust, the trust became a core member in the partnership on the basis of its strong history of clinical networks within and across South Yorkshire and Bassetlaw including the Cancer Network and more recently the Cancer Alliance and its history of collaboration with acute trusts as part of the Acute Vanguard, resulting in significant acute flows into SYB. Early on in the plan development process, formal representation was made to NHS England and NHS Improvement jointly between the Partnership and Chesterfield Royal Hospital NHS FT for it to become a full partner in SYB which was supported.

2.3.1. It is recognised that Chesterfield sits within a neighboring STP and likely that it may be subject to agreements with the neighboring STP which will need to be worked through to establish the medium and longer term relationships with SYB ACS which may change. There may also be changes to the way other organisation engage in the MoU as we develop and mature as an ACS. This also applies to emerging organisations, federations and legal partnership including primary care federations and therefore we will need to review as we develop.

2.4. It is anticipated that Parties ‘to’ will sign the agreement as an emerging ACS in SYB, be subject to delegated NHS powers and a new relationship with each other, with both NHS regulators and assures and package of support to transform health and care.
2.5. It is anticipated that Partners ‘in’ will **support the direction of travel** and work in partnership with SYB ACS. In some cases they may be subject to separate agreements in neighboring ACS and aligned agreements in ACP in Place within SYB.

2.6. The Parties to this agreement are:

2.6.1. Commissioners
- NHS Bassetlaw Clinical Commissioning Group
- NHS Barnsley Clinical Commissioning Group
- NHS England
- NHS Doncaster Clinical Commissioning Group
- NHS Rotherham Clinical Commissioning Group
- NHS Sheffield Clinical Commissioning Group

2.6.2. Healthcare Providers
- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
- Sheffield Children’s Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Health and Social Care NHS Foundation Trust
- Rotherham, Doncaster, South Humber NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

2.6.3. Heath Regulator, Assurer, Education and Training
- NHS England
- NHS Improvement
- Health Education England
- Public Health England

2.7. The Partners in this agreement are:

2.7.1. Local Authority partners
- Barnsley Metropolitan Borough Council
- Doncaster Metropolitan Borough Council
- Nottinghamshire County Council / Bassetlaw District Council
- Rotherham Metropolitan Borough Council
- Sheffield City Council

2.7.2. Provider partners
- Nottinghamshire Healthcare NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- East Midland Ambulance Service NHS Trust
- Doncaster Children’s Services Trust

3. Scope

3.1. The scope of South Yorkshire and Bassetlaw’s transformational plan covers all aspects of health and care, specifically:
- Public health
- Social care
- Primary care (including GP contracts)
Community services
- Dental and screening services
- Mental health services
- Acute services
- Specialised services
- Research and development
- Health education and innovation
- Governance
- Assurance
- Regulation
- Resources and finance
- Capital and estate
- Information sharing and digital integration
- Workforce
- Communication and engagement

3.2. Key enablers to include:
- Appropriate governance and regulation
- Delegation of resources from relevant national partners in line with the delegation of statutory functions
- Access to fiscal and regulatory levers that enable the improvement of health and wellbeing outcomes through wider determinants e.g. education, employment etc.
- Empowered system leadership, supported by effective governance and accountability arrangements
- A shared strategic approach to capital and estates planning
- A shared strategic approach to communications and engagement
- A shared strategic approach to workforce planning (clinical and non-clinical)
- Development of new payment mechanisms that remove perverse incentives and encourage/support new models of care
- Development of new information sharing system/processes

3.3. Operating as a shadow ACS through 17/18, will require flexibility in terms of ways of working. As a result, it is expected that the scope will remain fluid over this time period, to allow arrangements to be tested and amended as required to secure the optimal outcomes.

4. System objectives

4.1. In our STP submission we set out the objectives for the SYB systems aligned to the dimensions of the triple aims of the STP. These are summarised below:

4.2. The parties share the following system objectives

4.3. Care and quality
- Joined up, high quality services across hospitals, care homes, general practices, community and other services
- Easy and convenient access to services across settings and times of day
- Greater availability of services closer to home
- Better quality, more specialised hospital based care
- Greater availability and variety of non-health services that enhance people’s health
4.4 Health and wellbeing
- Better support for individuals in relation to physical and mental wellness and prevention
- A wider variety of healthy living schemes aimed at all communities within the population
- Active networks and links that connect people across communities and provide support
- Greater collaboration across the public sector relevant to the wider determinants of health

4.5 Finance and sustainability
- High quality, efficient services which provide good value for money for tax payers
- Reduced waste and greater efficiency in service delivery
- Greater use of available funding in enabling individuals to stay well and providing care closer to their homes
- A workforce and service that works flexibly to respond to individual needs and how people live locally, ensuring that the right skills and services are present in the right place and the right time

4.6 The NHS Constitution and Mandate sets out clearly what patients, the public and staff can expect from the NHS. SYB wants to build upon the rights and pledges of the Constitution and provide further opportunities for patients and the public to be involved in the future of their NHS - building on the Plan and the early conversations we have had with the citizens, patients and staff on these ambitions during February and March 2017.

4.7. The NHS Next Steps on the Five Year Forward View articulates why change is urgently needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. It sets out the development of new models and SYB is committed to being an early implementer and a test bed for new, innovative approaches of:

a. An Accountable Care System across SYB, with devolved freedoms, accountabilities and responsibilities and new relationships with member organisations, including NHS England, NHS Improvement and the ALBs
b. A closer relationship between commissioning and providing, integrating and aligning approaches to strategic planning and transformation of services
c. Accountable Care Partnerships with providers across SYB, delivering new models of acute and specialist care
d. New models of commissioning at system level for acute services, reducing variation and duplication and minimising transactional activity
e. Operating and managing a system control total for health
f. Accountable Care Partnerships in each local Place delivering integrated health and social care aligned to an overall SYB ACS

4.8. SYB needs to develop different relationships and have freedoms and responsibilities to optimise its potential. This Agreement builds the collaborative partnership established to develop the Plan, creates the platform for SYB to build on these to implement its ambitions through the invitation to SYB commissioners and providers to develop an emerging ACS.
5. Overarching principles

5.1. In the documents that were submitted as part of the STP submission on 21 October 2016, STP partners made a commitment to upholding the principles summarised below:

- **Improving quality and outcomes** - As a system, partners will work collectively to improve quality and population outcomes for people and reduce health inequalities for all of our local populations.

- **‘No worse off’ principle** – Decision making will be focused on the interests of people in SYB and our collaborative partnership will work to ensure those interests are served. We will ensure that our collective working and decisions do not lead to increased health inequalities or a worsening of health outcomes for any of our populations across SYB.

- **Inclusiveness** - All stakeholders (including commissioners, providers, patients, carers and partners) will be included in decision making and empowered to shape the system as it continues to develop. This will require active and sustained communications and engagement, informing and involving people early and in ways that allow them to get involved and help shape the direction of travel as we tackle the challenges.

- **Participation** - SYB will be involved in all decisions that materially impact on the health and care provided to its population or by its local partners.

- **Integration** - Partners will work to support improvements in outcomes through increased integration.

- **Subsidiarity** - Partners will work to support delegation of decision making to the most appropriate level, subject to robust governance and accountability mechanisms.

- **In the NHS family** - Healthcare services in SYB will remain part of the NHS. All the commitments described in this Agreement aim to (i) strengthen health and care in SYB and (ii) uphold the NHS values and standards.

- **Transparency** - Decision making will be underpinned by transparency and open information sharing between and amongst local and national partners.

- **Co-production** - National partners will take a co-production approach with SYB, in which decision making is facilitated by national partners to devolve and by local partners to ‘receive’ and deliver delegated functions.

- **Form aligned to function** - the delivery of shared outcomes will drive changes to organisational form where appropriate.

- **Wider system (NHS) focused** - Further delegation decisions will continue to be subject to consideration by national partners.
  - Local partners commit to working with national partners to ensure alignment between national policy objectives and the strategic direction taken locally.
  - Local partners will continue work to support nationally agreed priorities, including those set out in the Five Year Forward View.

- **Accountability** - All organisations will retain their current statutory accountabilities for health and social care and any commitments made will remain subject to organisations’ continuing ability to meet these accountabilities.

6. Direction of travel and key milestones

6.1. This document outlines our desire, individually and collectively, to achieve our vision of health and care in SYB. A significant amount of work has been delivered through working together locally to progress the system to its current state. However, we know that more work remains to be done and that a clear roadmap, agreed with all parties, will provide a clear and transparent way forward. We will continue to work together as local partners and with national colleagues to define the specific mechanisms and timescales associated with any further delegation of responsibilities and associated funding. Delegation of functions...
from national partners to local partners on behalf of the “system” will take place in a series of agreed steps, the speed and scale of which will likely be determined by:

- The achievement of assurance criteria determined by national partners
- Demonstrated capability
- The strength/appropriateness of governance arrangements
- The clarity of the delivery plan
- Suitability of gateway milestones

6.2. This approach will ensure that the system will only take on greater responsibilities and powers when it has the capability and resources to manage them appropriately.

Key milestones in the process include:

- By end July 2017, an MoU Agreement between SYB Parties giving the Framework by which SYB will ‘work as one’ to develop as an Accountable Care System and implement its Plan.
- By September 2017, taking staff and public feedback into account, we will refresh and rebrand the STP from a communications and engagement perspective to reflect becoming an ACS and what this means for the future of health and care.
- By September 2017 we will agree a delivery plan for 2017/19 for SYB ‘working as one’ to include priority areas including urgent and emergency care, primary care, mental health and learning disabilities and cancer to demonstrate delivery and enable testing of key ACS objectives outlines in 4.7.
- By September 2017, governance and an approach for agreeing and monitoring investment decisions within the ACS will be agreed.
- By the end of October 2017, with capital and transformation funding, we will agree how we will operate a system control total for health in 18/19.
- By end October 2017, we will agree a new NHS single oversight and assurance framework for SYB to be operational by April 2018 with aligned resources to support an integrated SYB ACS oversight and assurance function which will work with streamlined regional and national oversight arrangements.
- By end of October 2017, we will agree system and place commissioning responsibilities for agreed functions and services to enable alignment for ACPs to focus on new ways of contracting and allocating resources including population budgets, population health management and segmentation approaches for Place tier 0 - 1 and a system commissioning function for tier 2 and 3 services (all to be agreed).
- By April 2018, we will agree governance and approach for delivery of tier 2 services following the hospital services review outcome to support a horizontally integrated accountable network of hospital based services.
- Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18.
- By October 2017, SYB ACS will be ‘working as one’ with NHS England and NHS Improvement and working with ACPs in shadow form to provide support so that they will be legally constituted partnerships by April 2018 (at the latest).

Some dates amended to recognise slippage that has taken place.
7. Governance, accountability and assurance

7.0.1. This MoU does not replace the legal framework or responsibilities of our statutory organisations but instead sits alongside the framework to complement and enhance it. It recognises the complexity of how health and care organisations currently work and interact with each other to provide the best possible care and services.

7.0.2. Our health and care organisations are already coming together to form partnerships in Place; integrating health and care, commissioning and providing, including voluntary, community, GP, mental health and hospital services. These are taking varying forms and the governance and how this best supported in an overall ACS will be a key priority in 2017/18 and will be an area for which we will receive national guidance and support.

7.0.3. At the same time, some of these same organisations are forming necessary partnerships and coming together across South Yorkshire and Bassetlaw, either our hospitals, to ensure safe, sustainable and equitable acute services as a group of hospitals or our health commissioners to make consistent strategic planning and commissioning decisions as a system commissioner. In all of this, how the traditional separation between health commissioning and providing and the focus on competition is giving way to a focus on collaboration and integration.

7.0.4. All of this ‘pushes’ at the boundaries of the existing legal frameworks but other systems have found ways to work where there is evidence that it better serves to make improvement to the populations we serve.

7.0.5. Current statutory requirements for CCG assurance

7.0.5.1. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce healthy qualities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

7.0.5.2. NHS England must publish a report each year which summarises the results of each CCG’s assessment. The detail of the CCG assurance framework which underpins the publication is NHS England policy rather than set in statute or regulation.

7.0.6. Current statutory requirements for Foundation Trust oversight

7.0.6.1. NHS Improvement (NHSI - the operational name which brought together Monitor and the Trust Development Authority (TDA) and their associated teams on 1 April 2016) has a duty under the NHS Act 2012 to ensure the operation of a licensing regime for Foundation Trusts (and other providers of NHS services). The licensing regime covers requirements on FTs in relation to: general conditions; pricing; choice and competition; integrated care; continuity of services; and governance. The 2012 Act provides powers for NHS improvement to enforce or set conditions on a provider’s license.

7.0.6.2. The licensing regime is underpinned by the NHS Improvement Single Operating Framework which aims to help providers attain and maintain CQC ratings of good or outstanding. The framework is NHS Improvement policy rather than set in statute regulations.
7.1 Principles and underpinning assumptions

7.1.1. The Agreement is drafted by all Parties including NHS England, NHS Improvement and the ALBs where this is appropriate. The Agreement is intended to be flexible to achieve the right balance of ‘Give’ and ‘Get’ - financial, capacity, capability or devolved freedoms and flexibilities in return for improved delivery, operational, financial, quality, and transformational change.

7.1.2. There will be continual engagement and consultation with Boards, Governing Bodies and Councils throughout development. ACSs are not statutory bodies - they supplement accountabilities of individual statutory organisations. 2017/18 will be the first phase of SYB ACS and statutory organisations will continue with statutory accountabilities and relationships with NHS England and NHS Improvement, which will retain legal responsibility for CCG assurance and FT oversight respectively.

7.1.3. From September 2017, SYB Health and Care Partnership will adopt the ‘Working Together’ brand and as such will continue to deliver NHS Constitution and Mandate commitments in full and remain part of the wider NHS System. The Health and Care Working Together Partnership will deliver the FYFV ambitions through the development of an Accountable Care System with five constituent Accountable Care Partnerships and implementation of its Health and Care Working Together Plan (October 2016, revised April 2017) and five Place Plans.

7.1.4. The development of the Accountable Care System during 2017/18 will establish how individual organisations will be held to account for their contribution to the delivery of NHS Constitution and Mandate and the Health and Care Working Together Plan. Each of the five Places has confirmed they wish to continue to develop their Accountable Care arrangements and it is anticipated that these will be in shadow form in 2017/18. What constitutes ‘shadow’ is to be worked through and to be discussed and agreed with statutory organisations. SYB ACS ‘working as one’ with NHS England and NHS Improvement will work with ACPs providing support where required, especially where ACPs look to move to legal forms.

7.1.5. Operational management of the assurance and oversight processes will be through SYB working together and we will deliver the principles of the two national frameworks with a locally developed model with an integrated single oversight and assurance process within the ACS.

7.1.6. SYB will be assured once, as a place, for delivery of the NHS constitution and mandate, financial and operational control and quality.

7.2. NHS assurance, regulation and accountability

7.2.1. We would expect to move to a SYB relationship with NHSI and NHSE providing a single ‘one stop shop’ regulatory relationship with NHSE and NHSI in the form of streamlined oversight arrangements. An integrated CCG Improvement Assessment Framework (IAF) and Trust single oversight framework. CCGs will still require an annual review with NHSE. This will be in place from April 2018.

7.2.2. Single Accountability Framework

Within 2017/18, SYB working with NHS England and NHS Improvement will establish a Single Accountability Framework (SAF) which brings together the NHS England CCG Assurance
Framework and the NHS Improvement Single Operating Framework at a local level. The SAF will be implemented from 1 April 2018 and will set out:

- The **roles and responsibilities** of the parties to this Agreement (CCGs, providers, NHS England and NHS Improvement)
- The **scope of the SAF** including NHS constitutional commitments, national targets, quality indicators and productivity measures
- The **internal governance, assurance and reporting** system within SYB to support delivery of the SAF
- The **external assurance** and reporting system for SYB to NHS England and NHS Improvement
- The **agreed trigger points** and process where NHS England and NHS Improvement may exercise their statutory responsibilities for intervention.

7.2.3. The **Single Accountability Framework** will operate in shadow form within 2017/18. In shadow form, its scope will reflect the priorities of SYB (for example, cancer and urgent & emergency care).

7.2.4. The scope of the SAF **will widen as the ACS matures** until it covers the full range of NHS responsibilities. The timeline for the development of the scope of the SAF will be agreed between the Parties to the Agreement.

7.2.5. In 17 / 18 we will **align NHS England and NHS Improvement functions** and resources to support delivery of the ‘integrated within SYB ACS’ element of the Single Accountability Framework.

7.3. **Quality and safety**

7.3.1. South Yorkshire and Bassetlaw has a well established quality and safety approach at, organisation, Place and System level. **Very much of what is described in this MoU is about improving quality and safety.** This is both through our organisations choosing to work together on common challenges and on those issues which are most in need of a different way of working or most likely to deliver improvements through our joint efforts.

7.3.2. We commit to reviewing our approaches in light of developing as an ACS in 2017/18 to ensure our **quality and safety oversight and assurance** best supports how we are coming together in Place, as emerging ACPs and across SYB as an overall ACS.

7.3.3. There is growing evidence that the improvements we are aiming to achieve within our plan will give measurable **improvements in quality** ahead of any financial efficiency improvements. We would therefore want to develop clear quality metrics for SYB to enable us to track these quality improvements.

7.4. **Financial**

7.4.1. There are a number of areas that the ACS wishes to develop in conjunction with NHS England and NHS Improvement to support robust governance, accountability and assurance. The proposals will be developed through the SYB Directors of Finance Steering Group and ultimately approved by the Collaborative Partnership Board. The areas to be considered are outlined below.
7.4.2 How a system control total would work across the ACS?

This would focus on the following areas:

- How to create in year flexibilities including the potential use of a contingency or other specific business rules?
- How to reflect the impact of an agreed transformational scheme which differentially impacts organisational financial performance?
- Consideration of Place based control totals?
- Consideration of monitoring, management and reporting arrangements?
- Whether a set of efficiency indicators could be used to inform the application of a system wide control total?

7.4.3 Consideration of moving to a risk based approach to contracts?

Consideration will be given to developing a risk based approach to contracts where risks are identified and aligned to the organisation best placed to manage the risk and which supports the development of a system wide solution.

7.4.4 Investment decisions and business case development?

Agreeing a process to ensure investment decisions are optimal for the ACS footprint and are consistent with the ACS strategy. This will include a process on how any additional capital, transformation and any other external funding can be best deployed across the ACS. Developing a process to agree financial principles and assumptions to be used in ACS business cases.

7.4.4 Agreeing a process for business planning, financial reporting and performance

To develop an ACS business planning process including agreement to a consistent set of planning assumptions, where appropriate, and taking into account national guidance. To develop in partnership with NHS England and NHS Improvement a monthly ACS report which covers both financial performance and performance against key operational targets.

7.5. Operational

7.5.1 In 2017/18 and as part of our approach to developing an integrated single oversight and assurance approach within SYB, we will review operational assurance and oversight including our approach to planning and delivery assurance so that it is integrated within SYB. We will also align NHS England and NHS Improvement functions and resources.

7.6. Shadow Accountable Care System

7.6.1 In 2017/18, SYB will develop as an Accountable Care System. This will include collective decision making, governance and a single accountability framework which will align the individual statutory responsibilities of Parties to the Agreement to the delivery of the Health and care Plan (November 2016).

7.6.2 Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

7.6.2 Each of the five Places will develop an Accountable Care Partnership (ACP) to deliver the ambition set out in its Place Plan and the wider Health and Care Plan (2016). The five ACPs will operate in shadow form within 2017/18 and will be legally constituted partnership by 1 April 2018, at the latest.
7.6.3. The five ACPs will bring together health and care services from statutory and non-statutory organisations to create a **vertically integrated care system** in each Place. This will include hospital services from tier 1.

7.6.4. Each of the five Places will explore new ways of contracting and allocating resources to its ACP including **population budgets, population health management** and segmentation approaches.

7.6.5. The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

7.6.6. A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in SYB, integrating approaches to planning and transformation and explore new ways of contracting and allocating resources to network of hospital based care. From April 2018, we will start to **test the ‘contract once’ with the ‘network of provider’** to support sustainable services and drive improved outcomes for patients.

### 7.7. ACS governance

7.7.1. South Yorkshire and Bassetlaw has established collaborative governance. This governance **recognises statutory governance** of member organisations and where statutory organisations have come together to formally delegate to a **joint committee** or **Committees in Common**. It serves to support and supplement where agreed and appropriate, statutory governance and is the basis from which we will develop as an ACS.

7.7.2. A summary of SYB governance includes an **Oversight and Assurance Group**, a **Collaborative Partnership Board**, an **Executive Steering Group** and a range of programme Boards and project Boards.

**Summary schematic - South Yorkshire & Bassetlaw Health and Care Working Together Partnership Governance**

![Diagram of governance structure]
7.7.2.1. **Oversight and Assurance Group**: membership includes chairs from constituent statutory bodies including providers, commissioners, and Health and Wellbeing Boards with chief executives (CEOs) and accountable officers (AOs) in attendance.

7.7.2.2. **Collaborative Partnership Board**: membership includes CEOs and AOs from partner organisations including mental health and primary care, commissioning and local authority organisations, voluntary action groups, Healthwatch, NHS England and the ALBs. We also have clinical membership from primary and acute care. We plan to strengthen our Collaborative Partnership Board and review primary care input and wider clinical input and with lay membership.

7.7.2.3. **Executive Steering Group**: this group combines both the former STP executive steering group and the former finance oversight committee. Membership includes CEO and AO representation, together with directors of strategy, transformation and delivery and directors of finance.

7.7.2.4. **Programme Boards**: we have a range of programme boards delivering key priorities which are all led by a CEO and AO senior responsible officer (SRO). Each has a director of finance lead and a programme manager supporting.

7.7.3. This governance will remain in place for 2017/18 and during this time SYB will work with the Department of Health, NHS England, NHS Improvement and the ALBs as an ACS to review and establish governance that will best support us. This will be in place for 1 April 2018.

7.8. **Joint Committees and Committees in Common**

7.8.1. SYB CCGs, in partnership with North Derbyshire and Wakefield CCGs, have already established a joint committee and CCG governing bodies have delegated authority for the review of children’s surgery and hyper acute stroke services. The membership includes accountable officers, clinicians and lay members. During 2017/18, we will review the scope of delegation to reflect the outcomes of the Hospital Services Review and the Commissioning Review so that formal governance arrangements are in place by 1 April 2018.

7.8.2. SYB acute providers, in partnership with Chesterfield Royal Hospital NHS Foundation Trust and Mid Yorkshire Hospital NHS Trust, have established a Committees in Common (CiC) to better support collaborative working between trusts including streamlining decision making. The collaboration has already supported changes in a number of programme areas including support services (back office functions) and a number have been joint with commissioners working together across the same geographical area.

7.8.3. During 2017/18, we will review the scope of delegation to reflect outcomes of the Hospital Services Review and Commissioning Review so that governance arrangements are in place by 1 April 2018. At this stage, the wider acute provider partnership includes both acute providers and community mental health providers. However the CiC does not currently extend to community mental health providers.

7.8.4. The two programme offices and teams supporting commissioning and provider collaborations have now co-located to provide a joined up approach to planning and transformation delivery of acute services across SYB.
7.9. Place and accountable care development

7.9.1. CCGs and local authorities will continue to receive their respective health and care funding and to be statutorily accountable for their allocation.

7.9.2. Within 2017/18 each CCG will agree with its corresponding local authority the integrated governance structure which will support the allocation of resources to their ACP based on delivery of their agreed Place plan, wider Health and Care plan and agreed local outcomes.

8. Delivery improvement 2017/18-19

8.0.1. South Yorkshire and Bassetlaw has developed a number of priorities to support delivery of its Plan. These are led by chief executives and accountable officers with strong input from senior clinicians, public health, senior finance and operational colleagues from member organisations.

8.0.2. Transformation priority workstreams include:
- Urgent and emergency care
- Cancer
- Healthy lives, living well and prevention
- Primary care
- Mental health and learning disabilities
- Elective care and diagnostics
- Maternity and children’s

8.0.2.1. Enabler workstreams
- Workforce
- Digital and IT
- Carter, estates and shared services
- Finance
- Communications and engagement

8.0.3. For 2017/18 – 19 South Yorkshire and Bassetlaw has identified a focused number of key priorities for delivery improvement ‘working as one’. We will align resources and priority workstreams to support delivery of these key priorities at all levels within the emerging Accountable Care System and we will use these priorities to test new ways of working together and with NHS England and NHS Improvement to show additional benefits to patient and service delivery:

1. at organisational level
2. at Place (ACP) level
3. at System (ACS) level

8.0.4. Catalyst for change – in 2017/18 we will focus delivery improvements in urgent and emergency care, primary care, mental health and learning disabilities and cancer (or subsets of these priority areas) where we plan to make tangible improvements which will serve as a real catalyst for change across SYB. Each of our transformational workstreams has taken a unique perspective on how best they can contribute to delivering the ‘key improvements’ set out in the Next Steps on the Five Year Forward View. We will also take a unified approach to tackle efficiency improvement ‘working as one’ where this makes sense to do so.
8.1. Efficiency programmes, back office, Carter, Naylor

8.1.1. The efficiency programmes agenda is being addressed through two workstreams.

8.1.2. Firstly; The Provider Efficiency Group, which is responsible for the oversight of the acute and mental health trust providers programme and is addressing the eight nationally defined corporate service areas to ensure that collaborative opportunities are identified and maximised, including consolidation where appropriate. Its strategic objective is to develop systems that capture and optimise the cost effectiveness of corporate services so that services are assessed not only on direct costs and non financial quality indicators, but in relation to professional influence in driving efficiencies across trust systems, policies and processes. Its key aim is to reduce service costs with the summary data for showing the SYB position as 27/44, with potential savings of £4.4m to £10m, taking into account the national median and upper quartile benchmarking data from 2015/16. This is in line with estimated savings contained in the case for change submission October 2016.

8.1.3. The workstream’s immediate priority is to achieve efficiency savings that will help to reduce the financial gap and, in particular, focus on savings and innovations that can be delivered during 2017/18. To enable effective oversight and delivery of collective solutions, a phased approach has been agreed on the key service areas that have shown, through the benchmarking data, the greatest saving opportunities, and which take into account the synergies and dependencies between these service areas. These are HR services, finance including payroll, and procurement.

8.1.4. The ambition and commitment is to have regional networked arrangements using the same financial, HR and procurement solutions that will use consolidation and integration of transactional services as an enabler for common standardisation and streamlining of e-processes across all trusts to make efficiencies. Where and when appropriate, market testing may be undertaken.

8.1.5. The focus is therefore not just on changes to operating models but where with the use of technology and removal of transactional activity, significant efficiencies could be made. This is also reflected through formal HR streamlining and standardisation of priorities that target reduction of unwarranted variation and duplication across: workforce systems and compliance (including collaborative commercial relationships); general recruitment; bank and agency management (phase one focusing on medical agency including case for collaborative bank); occupational health/absence management; mandatory and statutory training; common bandings/gradings.

8.1.6. Secondly; there is a system wide Strategic Estates Group, the role of which is to provide strategic oversight, planning and direction to SYB clinical workstreams and the CCG Local Estate Forums (LEFs), enabling the delivery of more effective, Place based health facilities, property assets and health/public land across South Yorkshire and Bassetlaw. This workstream will support the implementation of a sustainable estate strategy that will help to deliver those objectives and also consider the findings of the Hospital Services Review and support the development and implementation of estates strategies arising from it. This will ensure a more integrated approach through the delivery of a smaller, more cost effective and efficient estate which is aligned more closely with the delivery of frontline public services.

8.1.7. The Strategic Estates Group brings together organisations which own health facilities, property assets and health/public land to facilitate the better use of all health and public
sector estate and will review principles for collaborative use of built assets. Its immediate priorities for 2017/18 – 2018/19 are based on three themes: strategic estates planning; aligning investment and disinvestment; and estates intelligence and spatial mapping.

8.1.8. Key outcomes are the production of a strategic estates plan and accompanying action plan, which sets out clear priorities for the delivery of better use of all local public land and property assets within respective geographical areas to deliver the estate objectives highlighted within the Health and Care Plan. It will also review the findings of the Naylor Review of surplus land and challenge partner organisations to address any recommendations, which will support the development of affordable estates and infrastructure plans and associated capital strategy.

8.2. Managing demand and optimising care

8.2.1. The elective and diagnostic care workstream will be responsible for the planning, oversight and governance of a regional or sub regional elective and diagnostic care system. Closing the elective workstream’s gap will be achieved by focusing on two priorities: reducing system demand and improving efficiencies in how we deliver our services. These themes will be delivered at Place and System levels through eight interventions; however, immediate priorities for 2017-2019 are described below.

8.2.2. Correct referral pathway – we will implement best practice demand management approaches that will reduce unnecessary or inappropriate referrals and ensure patients reach their most appropriate treatment first time. This will be achieved by piloting local solutions to advice and guidance and referral support with consideration to developing a regional solution. We will undertake local place based reviews of clinical pathways to reduce demand and attendance in hospital by developing community based services. We will support local organisations to improve utilisation of non face-to-face clinic delivery, alternative workforce models to drive efficiency and ensure effective access and discharge policies are in place to reduce unnecessary follow up appointments.

8.2.3. Procedures of low clinical value and clinical thresholds – we will develop a SYB policy for effective commissioning including a common set of controls and clinical thresholds for procedures to ensure adherence to best practice guidance.

8.2.4. Diagnostics – we will implement workforce and IT solutions that will reduce the demand and capacity gap in radiology reporting. We will work with the cancer workstream to develop diagnostic solutions that support early diagnosis.

8.2.5. Clinical efficiency – we will use benchmarking analysis (Getting It Right First Time) to identify and target variation along clinical pathways in order to deliver efficiencies. We will ensure our surgical activity is aligned to the appropriate setting and we will identify and transfer activity that can be delivered closer to home in the community.

8.3. General practice and primary care

8.3.1. Supporting and investing in general practice and primary care is a national priority mirrored by key priorities for all of our local Places. During the course of 2017 -19 we will deliver extended access to general practice for 100% of the local population by March 2019 and where possible, take steps locally to boost GP numbers including improving retention.
8.3.2. Expand multidisciplinary care including clinical pharmacists, mental health therapists, physician associates and increase the number of nurses in general practice.

8.3.3. Ensure 100% of GP practices are working together in hubs or networks by March 2019 that offer a greater scope of services which are increasingly capable of taking on population health responsibilities.

8.3.4. Expand multi-disciplinary care by deploying SYB’s share of 1300 clinical pharmacists and 1500 mental health therapists, as well as physicians’ associates and increase the number of nurses in general practice.

8.4. Urgent and emergency care (UEC)

8.4.1. We will continue to develop and strengthen the urgent and emergency care networks and partnership working through the UEC Steering Board, which builds upon the UEC Network established in 2015. A programme of work is currently being developed to take account of national requirements and the case for change described in the Health and Care Plan, with delivery models developed at place with a joint focus on redesigning the urgent and emergency care system and developing out of hospital services to reduce demand on A&E and acute beds.

8.4.2. The Five Year Forward View identified seven UEC priorities which will be included in the work programme. Specific priorities for 2017/18 include:

- We will work within Place and collectively across the System to ensure delivery of the four hour A&E standard and we will work as one with NHSE/I to agree improvement trajectories at System level with oversight on place delivery.
- We will work with Place to ensure the implementation of primary care streaming for each emergency department and with NHSE/I to agree at system level targets for activity flows through primary care streaming.
- We will work with Place to develop and identify the requirements for a clinical advisory service at three levels, 1) Place, 2) System 3) Regional to develop a hub and spoke arrangement to clinical advice using local clinicians/services where possible and scaling to system level where it is more efficient to do so.
- We will work as one with NHSE/I to agree at System level a realistic improvement trajectory to increase the volume of calls transferred from 111 to a clinician, working with providers of 111, out of hours and with place to deliver the ambition of 50% by March 2018 ensuring that NHS 111 connects into the appropriate clinical services and patients are directed to the most appropriate clinician/service.
- We will express an interest in becoming a pilot at system level for NHS 111 online in 2017/18 subject to the national roll out plan.
- We will work with Place to develop a plan to have at least one designated urgent treatment centre established by March 2018, which will include a review of existing urgent care centres, minor injury and walk in services to establish the baseline position and develop a plan to have a model for urgent treatment centres across the System in place by 2019.
- We will work with ambulance providers to implement the ambulance response programme and work as one with NHSE/I to develop realistic implementation plans. This will include working with Place to develop consistent offers on alternative pathways to conveyance to A&E.
• We will work with Place to improve patient discharges and flow through hospitals, including the establishment of a pilot to roll out the use of care home electronic bed states.

• We will work with Place to establish a common and shared approach to escalation management developing a plan to roll out a single system for better connections between Place and allow System level oversight of pressures in the UEC system.

• We will work as one with NHSI and NHSE to align differential standards to secure delivery of integrated urgent care between 111 and out of hours providers.

8.5. Mental health and learning disabilities (MHLD)

8.5.1 A number of priorities for the MHLD workstream have been identified, reflecting the requirements set out in Implementing the Five Year Forward View for Mental Health and identifying where and how a System level approach offers opportunities for improvements in service development and delivery. Key objectives for the workstream are:

• Development of core 24 liaison mental health services in all acute hospitals to support a reduction in pressure on the urgent and emergency care system, including reducing emergency admissions and length of stay for people with mental health problems.

• Providing support across all areas to develop integrated improving access to psychological therapies (IAPT) to ensure that people with long term conditions have their mental health needs met, reduce presentations for people with medically unexplained symptoms and improve patients’ ability to self manage to reduce reliance on healthcare services.

• Taking a collaborative approach to developing perinatal mental health pathways and services.

• Working with specialised commissioning on specialist beds and community alternatives across children and young people’s and secure mental health services.

• Improving the management of people with complex dementia needs, as part of moving care closer to home across the mental health and learning disabilities health and social care system.

8.5.2 In addition to supporting delivery of national objectives, the workstream is proactively addressing local issues, including gaps in services for adults with autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) and workforce issues. It will also work closely with the healthy lives, living well and prevention workstream to roll out innovations around social prescribing and employment support.

8.5.3 SYB will also oversee and support delivery of national objectives around access to services, including increasing access to psychological therapies, delivery of the 18 week referral to treatment target, and access to physical health checks for people with severe mental illnesses.

8.5.4 The workstream is also looking to explore opportunities for alternative commissioning and provider models where these will improve outcomes for patients, secure efficiency savings and secure service capacity and quality across SYB; including provider alliances and system commissioning.

8.6. Cancer

8.6.1 We will strengthen the newly formed Cancer Alliance by working with member organisations and at Place across the Cancer Alliance footprint; South Yorkshire, Bassetlaw and North Derbyshire. Our mandate and deliverables are explicitly articulated through the
Next Steps on the Five Year Forward View, the Cancer Taskforce strategy and our own Cancer Alliance Delivery Plan. Immediate priorities are outlined below:

- We will work to deliver the 62 day referral to treatment standard at System level as a single measure across our provider organisations by March 2018. This will create capacity to focus not only on the target but also enable us to focus on measures which hold the greatest significance to people affected by cancer such as quality of life, whilst also working to improve inter provider transfers within 38 days and improve earlier diagnosis.

- We will work with Place to implement interventions to achieve earlier diagnosis of cancer through raising awareness of signs and symptoms and maximising uptake in screening. We will understand capacity and demand across our diagnostics services, priorities in access to diagnostics and explore new models of access to diagnostics.

- We will support the delivery, through the local Cancer Alliance, of the strategic priorities to improve early diagnosis, services and outcomes for cancer patients as per the Cancer Taskforce report and facilitate the introduction of bowel cancer screening and primary HPV testing for cervical screening.

- We will continue to work with Place to fully deliver person centered care for people affected by cancer by implementing the living with and beyond cancer (LWABC) model of care.

- We have established an ‘advisory board’ of people affected by cancer to support decision making as part of our Living With and Beyond Cancer programme, one of our four Cancer Alliance workstreams. The Cancer Alliance board will also access this group on a topic by topic basis to support decision making on a range of issues such as performance.

### 8.7 Children’s and maternity care

**8.7.1** We have established a Children’s and Maternity Delivery Board to support system transformation across three initial priority areas:-

1. Following public consultation, to reconfigure children’s surgery and anaesthesia, developing new models of care with consistent management across providers, with sustainable care pathways that meet the newly specified standards of care.

2. For the acutely ill child, there is variation in the provision of care, and local assessment (in line with the national picture) identifies the current models are not sustainable, particularly in terms of workforce sustainability and coordinated care pathways. Therefore, there is a need to plan across a larger footprint and network provision. The immediate priority is to work together to develop sustainable new models of care for acute paediatrics, ensuring equity for children right across the SYB area through the adoption of a consistent ‘blueprint’ for services in each Place. This will be supported by a managed clinical network (MCN), ensuring a strong clinical input throughout. The blueprint will include paediatric acute services and consistent management across hospital settings, promoting demand management and supported discharge models in community settings, and the use of short stay assessment models.
3. For maternity services, we will work together to review the current offer and develop a single implementation plan for maternity care across SYB, proposing changes in line with the implementing better births, through our Local Maternity Systems (LMS).

8.8. Workforce

8.8.1. The Local Workforce Action Board (LWAB) is the main vehicle for driving and managing the workforce work stream. There is an overarching aim and ambition to make SYB an attractive place to work to both attract and retain staff.

The LWAB is focusing on three initial priorities:

- Development of the South Yorkshire and Bassetlaw region excellence centre (1 of 7 in England) which aims to raise the standard for support staff by promoting vocational education including focusing on apprenticeships, sharing resources and acting as a vehicle for innovation.
- Creation of a faculty of advanced clinical practice for the region which aims to ensure consistent practice standards and secure resources for advanced clinical practitioners (ACPs) and physician associates (PAs).
- Sustainable primary care; plans include an increase in GP, practice nurse and clinical support worker numbers, plus further development of physician associates, AHP practitioners, care navigators and clinical pharmacists.

8.8.2. As an enabling work stream, the LWAB is committed to supporting the SYB workstreams to identify their workforce requirements and transform their services.

8.9 Digital and IT

8.9.1. We will be relentless in focusing on the needs of our citizens and our patients and will seek opportunities for technology to improve the ability of our staff and our partners to meet those needs. Therefore, on the journey towards achieving our vision we will:

- Directly support and influence the work of the SYB priority and enabling workstreams to ensure they are able to maximise the benefit of digital solutions.
- Transform the way in which we engage with patients and citizens, supporting them to maintain their own health and wellbeing through digital solutions.
- Improve the way in which health and care providers engage at all levels to ensure an integrated approach to digital transformation.
- Accelerate mechanisms that promote record and data sharing as more care is delivered outside a hospital environment, enabling clinicians to provide the best care in all settings, particularly via the use of mobile technology.
- Exploit big data analytics to inform frontline clinical decision making, provide real time system level management information and better targeting of prevention initiatives.
- Support and empower our staff, patients and citizens so they can maximise the potential of new technologies as they become available to them.
- Invest in interoperability and infrastructure to enable change

8.9.2. Focus areas from a recent development workshop (and a draft programme of interventions) are:

- Digital inclusion
- Self help connect
- Wellbeing and recovery
- Healthcare co-ordination
8.10 Development of accountable care in Place and System

8.10.1. In 2017/18, SYB will develop as an Accountable Care System. This will include collective decision making, governance and a single accountability framework which will align the individual statutory responsibilities of Parties to the MoU to the delivery of the Health and Care Plan (November 2016).

8.10.2. Where it serves to improve population health outcomes and to meet the needs of patients, we will develop integrated working between commissioners and providers to transform services and reduce transactional costs in the system.

8.10.3. Each of the five Places will develop an Accountable Care Partnership (ACP) to deliver the ambition set out in its Place Plan and the wider Health and Care Plan (2016). The five ACPs will operate in shadow form within 2017/18 and will be legally constituted by 1 April 2018, at the latest.

8.10.4. The five ACPs will bring together health and care services from statutory and non statutory organisations to create an integrated care system in each Place. This will include hospital services from tier 1 (to be determined).

8.10.5. Each of the five Places will explore new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

8.10.6. The five ACPs will connect between the five Places and with a horizontally integrated network of hospital based care (Tiers 2 and 3 to be determined) to support seamless care for patients and to create the overall accountable care system (ACS) for South Yorkshire and Bassetlaw.

8.10.7. A system wide commissioning function will be in place within 2017/18 which will result from a reform of commissioning. We will build on approaches we have established in the STP, integrating approaches to planning and transformation and we will explore new ways of contracting and allocating resources to the integrated network of hospital based care.

8.11. Commissioning reform

8.11.1. During 2017/18, we will undertake a review of commissioning as part of our system reform. This will consider the development of ACP in Place and the developing ACS and will need to influence and respond to:

a. The five ACPs bringing together health and care services from statutory and non statutory organisations to create a vertical and horizontal integrated care system in each Place, include hospital services from tier 1 (to be determined).

b. Developing new ways of contracting and allocating resources to its ACP including population budgets, population health management and segmentation approaches.

c. Connect between the five Places and with a horizontally integrated network of hospital based care (tiers 2 and 3 determined by the hospital services review and
delivery of safe and sustainable services) to support seamless care for patients and to create the overall Accountable Care System (ACS) for South Yorkshire and Bassetlaw.

d. Having a system wide commissioning function in place within 2017/18 with new ways of contracting and allocating resources to the integrated network of hospital based care. From April 2018, contracting once for a range of agreed services with the network to support sustainable services and drive improved outcomes for patients.

Organisations have agreed to fully engage in the review to support the objectives and also to support implementation of the review recommendations.

8.12. Specialised services

8.12.1. In many clinical areas, including cancer, mental health and learning disabilities, the commissioning of services is often split across a number of different organisations, which makes it much more difficult to plan the provision of integrated care. Different sets of commissioners make separate decisions about areas of provision which – for the patient – combine to form their whole patient journey. In children and young people’s mental health, for example, young people move between types of provision that are commissioned and provided by separate organisations.

8.12.2. Whilst commissioning responsibilities have become more dispersed over recent years, our collective responsibility is to ensure that any differentiation in the commissioning of services does not manifest itself in fragmented services for patients. The development of the ACS gives the opportunity for specialised commissioners to work with local systems to ensure that joined up pathways are both commissioned and delivered across multiple health and social care settings and that the transitions between services are explicitly supported.

8.12.3. Commissioning specialised services across SYB helps remove some of the structural barriers that reinforce the separation between different elements of provision. It means that integration – for example between inpatient services and community services in mental health, or between chemotherapy and follow-up care in cancer – is ‘designed-in’ to local NHS services by joining up the commissioning processes across specialised and non specialised services, and across NHS and local authority care. Decision making is shifted as far as possible from the national to the local, to ensure it is based on the specific requirements of that geographical locality, giving local systems more say on how specialised budgets are spent in their area, making use of their deep understanding of their local population and giving them a voice in how resources are used locally in line with the established national service specifications.

8.12.4. The specialised services commissioned by NHS England include a diverse range of services, from the rare and highly specialised to more common/higher volume services. It follows that the most appropriate footprint for planning these services also varies (depending on a range of factors such as: patient numbers, shape of provision, financial risk, service specifications, strategy). NHS England has worked with its regional teams to undertake an initial segmentation of the services. This has resulted in developing a list of 20 services that are suitable for planning at populations up to 2.5m and thus at SYB level. During 17/18, work will take place with SYB and specialised commissioners to explore areas of focus that would be most relevant to work towards being part of the ACS.

8.12.5. Milestones:

• Areas of focus for specialised services to be planned at an SYB level agreed - Mar 18
• Shadow run budget for areas of focus for specialised services agreed - from Apr 18
• Ensure that for areas of focus agreed, any decisions on changes to services is made in partnership with SYB – from Apr 2018
• 18/19 – work towards integration of services within ACS.

Further work is still required to understand the staff resource implications of this work and this will be explored during 17/18.

8.13. Hospital services review

8.13.1. Both commissioners and acute providers across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield have all committed to support an independent review of hospital services. The review will be completed in 2017/18. The terms of reference have been established and include the following key review objectives:

a) Define and agree a set of criteria for what constitutes ‘Sustainable hospital services’ for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire (in the context of South Yorkshire and Bassetlaw).

b) Identify any services that are unsustainable and not resilient against these criteria, in the short, medium and long-term, including tertiary services delivered within and beyond SYB.

c) Put forward a future service delivery model or models which will deliver sustainable hospital services.

d) Consider the future role of a district general hospital in best meeting patient needs in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Health and Care Plan and emergent models of sustainable service provision.

9. National and regional support from the Department of Health, NHS England, NHS Improvement and the Arms Length Bodies

9.1. Capacity and capability

9.1.1. To support SYB ACS development there will be a process of aligning resources from ALBs to support delivery and establishing ACS integrated single assurance and regulation approach.

9.1.2. National capability and capacity will be available to support SYB from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9.2. Financial including transformation and capital funding

9.2.1. In year one, an allocation of central funding has been ring fenced for the eight accelerating ACSSs only.

9.2.2. SYB will therefore receive a share of the £450 million transformational funding allocated for the eight high performing systems and a share of the £325 million capital funding. How this funding is allocated to deliver our system plan is to be worked through and agreed.

9.2.3. Bespoke support to work through financial governance and operating a shared system control total and alternative payment models.
9.3. Nationally supported workstreams and peer support

9.3.1. National ACS workstreams/learning set have been established to work with and support the eight named Accountable Care Systems including:

- Communications and public engagement
- Leadership
- Scaling up primary care
- Urgent and emergency care
- Devolved transformation funding
- Spreading new care models and integrating care
- Capital funding
- Shared system control totals
- Alternative payment models
- System wide efficiency opportunities
- Governance
- Streamlining oversight
- Future of commissioning functions
- External partnerships to support population health.
### Glossary of terms and acronyms

**ACP**  
Accountable Care Partnership. The partnerships forming in each of the five local places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

or  
Advanced Clinical Practitioner

**ACS**  
Accountable Care System; here covering South Yorkshire and Bassetlaw with five constituent Places of Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

**ALB**  

**AO**  
Accountable Officer at a Clinical Commissioning Group

**Carter**  

**CCG**  
Clinical Commissioning Group

**CEO**  
Chief Executive Officer

**CiC**  
Committees in Common

**CPB**  
Collaborative Partnership Board

**CQC**  
Care Quality Commission, the independent regulator of all health and social care services in England

**DoH**  
Department of Health

**FT**  
Foundation Trust; a semi-autonomous organisational unit within the NHS

**FYFV**  
Five Year Forward View; a strategy for the NHS (2014)

**GB**  
Governing Body - governance of Clinical Commissioning Groups

**GP**  
General Practitioner

**GPFV**  
General Practice Forward View

**HEE**  
Health Education England

**HSR**  
Hospital Services Review

**IAPT**  
Improving Access to Psychological Therapies

**JC CCG**  
Joint Committee of Clinical Commissioning Groups - a statutory body where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.

**LA**  
Local Authority, an administrative body in local government
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<thead>
<tr>
<th>LWAB</th>
<th>Local Workforce Action Board sub regional group within Health Education England</th>
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<tbody>
<tr>
<td>MCP</td>
<td>Multi-specialty community provider</td>
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<td>MHLD</td>
<td>Mental Health and Learning Disabilities</td>
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<td>MoU</td>
<td>Memorandum of Understanding; a formal agreement between two or more parties to establish official partnerships</td>
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<td>Naylor Review</td>
<td>Sir Robert Naylor’s review of NHS property and estates and how to make best use of the buildings and land (2017)</td>
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<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHS 111</td>
<td>A national free to call single non-emergency number medical helpline</td>
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<td>NHSE</td>
<td>NHS England</td>
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<tr>
<td>NHSI</td>
<td>NHS Improvement; operating name for Monitor, NHS Trust Development Authority and teams from 2016</td>
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<tr>
<td>PA</td>
<td>Physician’s Associate</td>
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<tr>
<td>PACS</td>
<td>Primary and Acute Care System</td>
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<tr>
<td>Place(s)</td>
<td>One of five geographical subdivisions of SYB with the same footprint as the ACPs</td>
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<tr>
<td>SAF</td>
<td>Single Accountability Framework</td>
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<tr>
<td>SRO</td>
<td>Senior Responsible Officer, the visible owner of the overall business change, accountable for successful delivery</td>
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<tr>
<td>STP</td>
<td>Sustainability and Transformation Plans (2016); the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care</td>
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<tr>
<td>SYB</td>
<td>South Yorkshire and Bassetlaw</td>
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<tr>
<td>TBA</td>
<td>To be announced</td>
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<td>TBC</td>
<td>To be confirmed</td>
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<td>UEC</td>
<td>Urgent and emergency care</td>
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<tr>
<td>Vertical integration</td>
<td>FYFV delivery next steps: horizontally operating provider organisations simultaneously operating as vertically integrated care system, partnering with local GP practices formed into clinical hubs serving 30,000–50,000 populations</td>
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<tr>
<td>Horizontally integrated</td>
<td>FYFV delivery next steps: Where provider organisations collaborate to form care systems. There are different forms; from virtual to actual mergers, for example, having ‘one hospital on several sites’ through clinically networked service delivery</td>
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Board Meeting: 26 September 2017

Report: Estates Plan
Presented by: Chris Holt, Director of Strategy and Transformation
Author(s): Chris Holt, Director of Strategy and Transformation, John Cartwright, Director of Estates and Facilities

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / responsive / well-led

Risk Reference:
BAF: B1 (2017/18 BAF)
Corporate Risk Register: No risks on risk register

Purpose of this paper:
This paper presents a short update of the Trusts estates strategy, which was originally presented to Trust Board in June’17, by providing a greater alignment between the estates schemes and priorities identified within the original estates strategy, with the priorities identified within the Trust 5-year strategy.

The paper also provides a short update regarding the implementation of the various schemes identified within the overall strategy document.

Summary of Key Points:

- The estates strategy was developed during late 2016, with the help of external consultants, to develop a strategy and set of priorities and schemes around the management of the Trust estate, and how the estate should support the overall strategic vision of the Trust. This was then presented to the Trust Board for approval in June 2017.

- Due to the timing of the overall 5-year strategy and the commissioning of the work to develop the estates strategy, it was agreed that an updated document would be represented in September 2017, which aligned the schemes and priorities more closely with the sense of strategic direction identified within the 5-year strategy. This short paper presents this updated document.

- The strategy has been updated with the help of the Trust’s Clinical Directors, service managers and Executive Officers.

Board action required:
For approval
1.0 Introduction

1.1. This paper provides a summary of the key priorities and schemes identified within the original estates strategy and aligns these schemes against the strategic clinical pathways identified within the Trust 5-year strategy.

1.2. Each pathway is taken in turn, with a short summary around the Trust strategic approach and then the schemes are then summarised as being those which support this general direction. This helps articulate why these schemes are deemed important and provides a degree of assurance that the schemes identified are aligned with the overall strategic direction of the Trust.

1.3. There are then a small number of schemes which do not fit into any of the specific pathways and are more corporate or generic in the nature and these are summarised in the final section.

2.0 Urgent, Emergency and Acute Care

2.1. A key part of delivering health care services across Rotherham and within the Trust is the provision of a comprehensive urgent and emergency care service. This will provide for patients needing both urgent, emergency and acute care services.

2.2. As robust management and sustainability for the whole pathway is fundamental in providing care to the local population, it is also acknowledged that increased partnerships and joint working arrangements will be required to achieve this.

2.3. The four priorities outlined across the Urgent, Emergency and Acute Care pathway are as follows:

2.3.1. Development of an integrated urgent and emergency care portal
This has seen the design, development and build of a new Urgent and Emergency Care Centre (UECC) to collocate primary, secondary, community care along with mental health teams. It will also require an expanded Care Coordination Centre and GP Out of Hours facility, all co-located together.

2.3.2. Development of acute assessment units and ambulatory and frailty pathways
Underpinning the integrated UECC are redesigned assessment units for medical (AMU), surgical (SAU), paediatrics (PAU) and gynaecology (GAU) patients. There is also the development of new pathways / units to cover Ambulatory Care and Frailty.

2.3.3. Reconfiguration and management of the acute bed base
To support the emergency portals will be an appropriate in-patient specialty bed base. This will require wards which are regularly refurbished to meet privacy, dignity and cleanliness / PLACE standards.

2.3.4. Sustainable acute based services and specialist sub-regional pathways
To support a thriving district general hospital there will need to be a range of acute based services provided. Some of these the Trust has already been successful in securing; such as being awarded the contract to be the second implant centre for complex cardiac devices across South Yorkshire. Supporting such specialties will require appropriate investment in capital and equipment. Other key specialties include photopheresis and the Trust’s nationally recognised service, which continues to grow and requires investment to provide appropriate capacity and respiratory
services, with the Trust running the nationally recognised Breathing Space facility, which has the opportunity to collocate all respiratory services in one location.

2.4. The schemes identified within the estates strategy to support the above priorities are as follows:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Short Description</th>
<th>Timescale</th>
<th>Next Milestone(s)</th>
<th>Funded 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Care Centre (Inc. Multi agency)</td>
<td>Construction of new Urgent and Emergency Care Centre.</td>
<td>Short term</td>
<td>Complete</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Frailty Assessment Unit | Delivery frailty unit and team | Short term | ● Redevelop CDU / Frailty Unit – Q2 17/18  
● Business Case delayed to Q3 | Yes |
| Catheter Lab Equipment replacement, Cardiology expansion and investment | Cardiology is in need of expansion and future investment in replacing the aging cardiology equipment. Also investment required to support status as 2nd implant site for complex cardiac devices | Short / Medium term | ● Business case for replacement of Cath Lab equipment approved. Due completion Q3  
● Business case for expansion – Q3 17/18 | Part (Cath Lab) |
| AMU Short Stay and Assessment | Development of expanded AMU with assessment and short stay facilities Linked to SAU and B4 / B5 | Medium term | ● Options appraisal Q4 17/18 | No |
| Surgical Assessment Unit (B1) | Opportunity to relocate Ward B4/B5 onto Ward B1 to provide assessment / inpatient surgical short stay unit | Short/ Medium term | ● Options appraisal early Q3 | No |
| Ambulatory Care | Development of dedicated ambulatory care unit. Potential use of B6 | Medium term | ● Options appraisal Q4 17/18 | No |
| Gynae Assessment Unit (GAU) | Expansion of GAU to ensure provision of ring-fenced beds and facilities | Medium term | ● Business case for establishment – Q3 17/18  
● Implementation – Q4 17/18 | No |
| Ward Redevelopment / Bed Reconfiguration | Undertake a phased ward refurbishment programme to provide fit for purpose accommodation, increase single room occupancy, more dementia friendly wards, eradicate environmental privacy and dignity issues | Medium / Long term | ● Business case in Q3 19/20 | N/A |
| Photopheresis Investment | Potential need for expansion due to opportunity to expand service | Medium / Long term | ● Options appraisal - Q1 18/19 | N/A |
Breathing Space: Respiratory Services

Breathing Space has the potential to house the majority of respiratory services. As an operational service priority, Breathing Space also needs piped oxygen. Short / Medium term

- Completion of works – Q4 17/18

Part (Q2)

3.0 Elective Care

3.1. Elective care pathways are currently provided across medical, surgical and orthopaedic specialties such as general surgery, orthopaedic surgery, ENT, urology, ophthalmology, maxillofacial surgery, cardiology, gastroenterology, dermatology, gynaecology and endoscopy among others. These are provided in both inpatient and outpatient settings with well developed, well run anaesthetics and theatre teams. Much of the elective care pathway contributes significantly to the financial performance of the Trust.

3.2. The four priorities across the Elective Care pathway (including cancer) will be;

3.2.1. Development of elective inpatient and day-case surgery offering
Developing and building upon the strengths within the current elective care offering is crucial if we wish to grow the elective offering across the STP footprint. Our surgery day-case unit has grown significantly over the last 10 years and requires investment to deal with the current and forecast demand as well as to provide privacy and dignity for patients. We are also looking to provide a dedicated paediatric day surgery facility to avoid all children coming in on an elective pathway having to start and end their stay on the inpatient children’s ward which is detached from theatres and occupies beds within the non-elective bed base.

3.2.2. Effective and efficiently organised outpatient services
Running efficient outpatient services also requires having fit-for-purpose estate and facilities to ensure services are right-sized to meet demand, are co-located to adjacent and support services and provide the right clinical environment for patients and workforce alike. A number of clinical services, run in an outpatient setting require investment over the coming years to keep pace with demand and patient requirements.

3.2.3. Development of acute & community integrated working
Much of the focus within this priority is about identifying appropriate community based solutions for patients who do not need acute based care. From an estates perspective this will be addressed within the intermediate care priorities.

3.2.4. Sustained delivery of waiting time standards for elective and cancer care
It is strategically important for the Trust to continue to support the delivery of elective waiting time standards in order to be a partner of choice for elective activity for ACS partners. As part of the focus on cancer pathways including the increased bowel screening programmes nationally, as well as to support the 18 week RTT, it is also necessary to have a sustainable endoscopy solution, and this will require investment to provide a more robust service.

3.3. The schemes identified within the estates strategy to support the above priorities are as follows:
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Short Description</th>
<th>Timescale</th>
<th>Next Milestone(s)</th>
<th>Funded 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatre Processes and maintenance</td>
<td>Day Surgery needs investment in order to meet privacy and dignity issues; there are also capacity constraints within the current configuration, which are expected to worsen and a larger recovery space is needed.</td>
<td>Short / Medium term</td>
<td>• Feasibility work currently being progressed around Day Surgery in Q3</td>
<td>No</td>
</tr>
<tr>
<td>Theatre 11</td>
<td>Theatre 11 requires a new ventilation system.</td>
<td>Short term</td>
<td>• Theatre 11 refurbishment completed in Q2</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric Day Surgery</td>
<td>Potential for dedicated paediatric day surgery to avoid all day surgery cases being admitted onto the children’s ward</td>
<td>Short / Medium term</td>
<td>• Options appraisal (with SCH) - Q4 17/18</td>
<td>No</td>
</tr>
<tr>
<td>Orthotics (Outpatients)</td>
<td>Review and refurbishment / relocation of the Orthotics department due to poor environment</td>
<td>Medium term</td>
<td>• Options appraisal – Q1 18/19</td>
<td>N/A</td>
</tr>
<tr>
<td>Fracture Clinic (Outpatients)</td>
<td>Clinic Capacity issues</td>
<td>Medium Term</td>
<td>• Options appraisal 19/20</td>
<td>N/A</td>
</tr>
<tr>
<td>Integrated Sexual Health Accommodation (Outpatients)</td>
<td>Relocation and alignment to provide a single integrated sexual health service on a single site as per new service contract.</td>
<td>Short / Medium term</td>
<td>Complete</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Physics – Respiratory Physiology Separation</td>
<td>Medical Physics is a highly developed service with environmental issues and refurbishment needs.</td>
<td>Medium term</td>
<td>• Options appraisal - Q1 18/19</td>
<td>N/A</td>
</tr>
<tr>
<td>Ophthalmology Co-location / Re-location (Outpatients)</td>
<td>Current service is split over two levels (Ward B6 and OPD) and colocation would improve efficiency and growth options. Opportunity to locate off-site potentially RCHC or across STP</td>
<td>Medium term.</td>
<td>• Options appraisal – Q3 17/18</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes Centre Reconfiguration (Outpatients)</td>
<td>Potential to move service off main hospital site to RCHC.</td>
<td>Medium Term</td>
<td>• Options appraisal – 19/20</td>
<td>N/A</td>
</tr>
<tr>
<td>Redevelop vacant areas in Physiotherapy for Orthotics including Physiotherapy enabling works</td>
<td>Review and refurbishment / relocation of the Orthotics department due to poor environment, requires some enabling works in Physiotherapy for this to be achieved</td>
<td>Medium term</td>
<td>• Options appraisal – Q1 18/19</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiology refurbishment and equipment</td>
<td>The service has capacity as well patient privacy and dignity challenges. The provision of a new satellite unit adjacent to</td>
<td>Short / Medium term</td>
<td>• Options appraisal – Q3 17/18,&lt;br&gt;• Some privacy and dignity</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Outpatients could help manage patient flow and use of new technologies will alleviate pressures.

### MRI Scanner

Second MRI scanner will be a priority in 2-3 years, it is envisaged that this will not require capital funding and will be located in current department through room reconfiguration.

- **Medium / Long term**
- **Options appraisal** Q4 17/18
- **N/A**

### Endoscopy expansion & new decontamination unit

Endoscopy requires expansion as current environment is struggling with capacity and also urgently needs a new decontamination facility. This latter is high risk for the Trust if not resolved.

- **Short / Medium term**
- **Decontamination Unit - Secure funding Q3 – 17/18**
- **No**

### Relocate Greenoaks services

The building is deemed not fit for purpose, some of the current services could be in the community, such as RCHC so options around refurbishment and / or relocation need to be considered. Demolition of existing building is also included.

- **Short / Medium term**
- **Options appraisal and feasibility study – Q3/4 17/18**
- **No**

### Dermatology Reconfiguration

Potential to move service off main hospital site to RCHC

- **Medium Term**
- **Options appraisal – 19/20**
- **N/A**

## 4.0 Intermediate Care

4.1. Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of admission to hospital. In Rotherham we have a combination of residential and home based intermediate care provision. These deliver the required care, nursing and therapy support, to ensure that patients can remain safely in the community. We have a good reputation for delivering intermediate care services but here is much more that we can do to promote independence and reduce reliance on stretched health and social care services.

4.2. The four priorities across the Intermediate Care pathway will be;

4.2.1. Development of a Reablement Village

This priority is about the consolidation of current intermediate care provision into a single location with services provided from multiple agencies and ‘wrapped around’ the patient so they receive care in a more integrated and optimal way, covering physical, mental and social wellbeing. The current planning timescales are long term and will require potential use of existing services at Badsley Moor Lane site (Breathing Space, Park Rehabilitation, and Rotherham Intermediate Care Centre).

4.2.2. Reconfiguration of the community bed base
Ensuring we have the appropriate community bed base is critical in supporting acute, community and domiciliary care based services. This will require looking at current community bed base and right-sizing to meet the future needs, which will include the use of Oakwood Community Unit as part of this review and planning.

4.2.3. An enhanced Integrated Rapid Response Service
Developing an Integrated Rapid Response Service supports patients who are at immediate risk of admission as well those who are medically fit for discharge and can be cared for at home, by providing short term reactive care. Going forward it will be about ensuring appropriate co-location of IRR type services with other services such as Care Coordination Centre, Out-of-Hours services and community locality teams.

4.2.4. Reconfiguration of therapy services
Allied Health Professional’s (AHP’s) expertise in rehabilitation and enablement is vital to shift away from over reliance on hospitals and professional interventions. As with IRR, in terms of estates, it is about ensuring we have appropriate facilities in place to support co-location of teams as close to patient need as possible.

4.3. The schemes identified within the estates strategy to support the above priorities are predominantly covered within the Community pathway approach, with the emphasis on One Public Estate, shared used of facilities with partner agencies and the development of locality based working. However, the following scheme is specific:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Short Description</th>
<th>Timescale</th>
<th>Next Milestone(s)</th>
<th>Funded 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care – Reablement Village</td>
<td>Opportunity to relocate post-operative orthopaedic patients in alternative care setting. Linked to the wider intermediate care (reablement village) solution</td>
<td>Medium / Long term</td>
<td>• Launch of community bed base options – Q4 17/18</td>
<td>N/A</td>
</tr>
</tbody>
</table>

5.0 Community Services

5.1. Rotherham is fortunate in that it has one Clinical Commissioning Group, one local authority, one mental health provider and a vertically integrated Trust that delivers acute and community care services. This provides an opportunity for close partnership working and integration in the community. The main focus of the community services pathway work is on integration across health and social care. Integration will reduce levels of fragmentation. It will deliver efficiencies whilst at the same time improve the quality of care delivered. Successful integration of community services will mean that patients will experience a holistic service, where they only have to tell their story once and where there is a coordinated response to support provided.

5.2. The five priorities for community health services over the next five years will be;

5.2.1. Development of integrated localities
The focus within this priority is building upon the locality pilot which was launched within the Village and expanding this approach across the Rotherham localities. This
will require colocation of multi-disciplinary teams and professionals and using the One Public Estate opportunities that closer working in collaboration will bring.

5.2.2. Extending the role of the Care Coordination Centre (CCC)
The CCC acts as a portal into community services and has the opportunity to expand into a single point of access across physical, mental and social care (all community-based health and social care services. This will require an appropriate location and services.

5.2.3. Expansion of community diagnostics and imaging
The Trust currently provides all diagnostic services on the hospital site and will be looking to transfer some diagnostic and imaging services into the community to provide ease of access and capacity constraints. The Trust is taking over the diagnostic services at Rotherham Community Health Centre and this provides an excellent platform to expand this offering.

5.2.4. A coordinated approach to care home support
This priority is about working closer with care homes and has no immediate impact in the estates strategy as per the current strategy. The major change in this area would be if the Trust was to invest within the care home sector to run specific facilities, of which there are no immediate plans to do so at the moment.

5.2.5. Good quality End-of-Life care
Two of the key aspects in the provision of good quality end-of-life care is about being treated as an individual with dignity and respect and also supporting people to be in their preferred place of care. In the event that this is in the hospital setting, the provision of more private, individual settings such as the Purple Butterfly rooms support this and will be addressed as part of the Ward Refurbishment aspect of the estates strategy (see section 2.4).

5.3. There are a number of other community based services which require addressing as part of the estates strategy, and these include specifically;

5.3.1. REWS: requires a strategic review as to the long term provision of this service as the current accommodation requires significant investment to make it fit-for-purpose

5.3.2. RCHC Utilisation: as services such as the Walk-In-Centre and GP OOH’s have relocated from the facility, this has provided vacant space which can be potentially utilised by the Trust to support the move away from hospital based services

5.4. The schemes identified within the estates strategy to support the above priorities are as follows:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Short Description</th>
<th>Timescale</th>
<th>Next Milestone(s)</th>
<th>Funded 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Estate and Transformation</td>
<td>Expand the locality based approach and provide dedicated MDT accommodation for locality teams</td>
<td>Medium / Long term</td>
<td>• Locality evaluation Q4 17/18</td>
<td>N/A</td>
</tr>
<tr>
<td>District wide Trust collaboration</td>
<td>Working with partners and the One Public Estate agenda to provide</td>
<td>Short / Medium term</td>
<td>• SHSR – Q4 17/18</td>
<td>N/A</td>
</tr>
</tbody>
</table>
combined services in the communities and utilize any under used space

<table>
<thead>
<tr>
<th>RCHC Utilisation</th>
<th>There is a potential opportunity to relocate services to RCHC; although this is dependent on the views of the CCG into the future use of this vacated space. Investment is to explore options appraisal and implement.</th>
<th>Medium Term</th>
<th>• Options appraisal – Q3 17/18</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>REWS</td>
<td>Service requires significant investment if it is to continue to provide decontamination services and have a building that is fit for purpose</td>
<td>Short term</td>
<td>• Service review being undertaken in Q3 17/18</td>
<td>No</td>
</tr>
</tbody>
</table>

### 6.0 Maternity, Children and Young People

6.1. Maternity, Children and Young People covers a portfolio of services which include; children’s assessment and inpatients, maternity services, sexual health, the special care baby unit and children’s outpatients. The Trust will develop a new service model that responds to the current challenges in the health economy. This proposed model is based upon the principle that every child should have access to high quality care. The ambition is to provide care closer to home, bringing together primary care, community services and social care within one holistic service. It is also our ambition to develop a high quality, sustainable inpatient and ambulatory care offer for children.

6.2. The four priorities for maternity, children and young people services over the next five years will be;

6.2.1. Securing the future of maternity services
As maternity is a core service for the Trust it is important to secure its provision. This priority has no immediate estates impact until the review has been completed, although the estates team will be part of any review to secure input into options

6.2.2. Reconfiguration of children’s community health services
As with the locality based approach in adults (see 5.2.1) the priority will be about how we develop appropriate hubs out of which multi-disciplinary teams can be co-located and support joint, closer, integrated working, and will build upon the opportunities within the One Public Estate agenda

6.2.3. Partnership arrangements on inpatient care
This priority is about developing a more effective, sustainable acute care model of care. This will see the provision of ambulatory care and short stay assessment (see 2.4) whilst also exploring the opportunity to work with partners across South Yorkshire and Bassetlaw, specifically Sheffield Children’s Hospital on the most sustainable way to provide inpatient care considering the workforce shortages experienced by the majority of Trusts. This will also need to include Special Care Baby Unit (SCBU) provision, and there are short terms investments needed within the Trust to address some immediate needs.
6.2.4. Supporting the transition from children to adult services
The focus within this priority is about the joining up of services and estates impact and support needs to be developed going forward, but will again draw upon joint collaboration and integration and the One Public Estate approach.

6.3. The schemes identified within the estates strategy to support the above priorities are as follows:

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Short Description</th>
<th>Timescale</th>
<th>Next Milestone(s)</th>
<th>Funded 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children`s Ward and Assessment area</td>
<td>Potential expansion of Children’s assessment and short stay focus and link in to paediatric surgery</td>
<td>Long Term</td>
<td>• Options appraisal (with SCH) - Q4 17/18</td>
<td>N/A</td>
</tr>
<tr>
<td>Special Care Baby Unit refurbishment</td>
<td>Upgrade of SCBU, refurbishment and potential HDU facility</td>
<td>Medium Term</td>
<td>• Options appraisal (with SCH - Q4 17/18</td>
<td>N/A</td>
</tr>
</tbody>
</table>

7.0 Other initiatives identified within the overall strategy

7.1. In addition to these clinical priorities are a range of separate organisational priorities that need to be considered that ensures the Trust provides a safe, secure and compliant environment that meets the expectations of our patients, visitors and staff and are captured under “Other initiatives” table below.

7.2. Many of these initiatives will require further work and consideration, and a number are not seen as immediate priorities within the coming 12-18 months, although priorities can change and these can be brought forward if necessary.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Short Description</th>
<th>Timescale</th>
<th>Next Milestone(s)</th>
<th>Funded 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Records: Storage issues</td>
<td>Options appraisal required on long term strategy for storage of medical records which could be purpose unit on hospital site, off-site storage or outsourcing</td>
<td>Medium / Long term</td>
<td>• Options appraisal – 19/20</td>
<td>N/A</td>
</tr>
<tr>
<td>Woodside redevelopment</td>
<td>Review strategy for use of Woodside, potential to bring in more community bases</td>
<td>Medium / Long term</td>
<td>• Develop future strategy 18/19</td>
<td>N/A</td>
</tr>
<tr>
<td>6 Facet Surveys</td>
<td>Complete 6 facet surveys in line with NHS guidance, currently only undertake two, Physical condition and statutory compliance</td>
<td>Short/Medium term</td>
<td>• Q1 18/19 commence</td>
<td>N/A</td>
</tr>
<tr>
<td>D Level Reconfiguration</td>
<td>Development of D level accommodation, require option appraisal</td>
<td>Medium term</td>
<td>• Options appraisal 18/19</td>
<td>N/A</td>
</tr>
<tr>
<td>Research and Development</td>
<td>Current accommodation becoming unsuitable for service needs</td>
<td>Long term</td>
<td>• Seeking external funding</td>
<td>N/A</td>
</tr>
<tr>
<td>Accommodation Moves</td>
<td>General accommodation moves to suit service re-development,</td>
<td>Medium / Long term</td>
<td>• From Q1 19/20</td>
<td>N/A</td>
</tr>
</tbody>
</table>
transformation initiatives efficiencies of scale requirements

<table>
<thead>
<tr>
<th>Residential accommodation</th>
<th>Returns to Trust ownership in Oct’17, with potential to generate additional income and provide better accommodation</th>
<th>Medium / Long term</th>
<th>• Accommodation Strategy to be reviewed in 18/19</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oakwood Hall</td>
<td>Grade 2 listed building in need of significant investment</td>
<td>Long term</td>
<td>• Seek external funding to redevelop building – on-going</td>
<td>N/A</td>
</tr>
</tbody>
</table>

8.0 **Five year capital plan**

8.1. The strategy has identified that the forecasted capital programme over the next 5 years to implement the strategy is £17.393m.

8.2. The strategy has identified that the forecasted minimum programme for Estates maintenance schemes over the next five years to meet all statutory and compliance standards for “safety critical” backlog expenditure items is £10.3m.

8.3. The Trust has to date completed the following schemes identified in the 2017/18 capital plan:
- Urgent and Emergency Care Centre
- Integrated Sexual Health Services Accommodation
- Refurbishment of Theatre 11

8.4. The strategy is a five year forward looking plan, focusing on the Trusts current two-year financial operating plan and the immediate needs of each Service during this period. This paper has also provided the broad timeframe, the next main milestone and whether funding is in place within the 17/18 capital plans to complete the work within the individual tables above.

8.5. **Five year capital plan (2017 – 2022):**

<table>
<thead>
<tr>
<th>Schemes</th>
<th>2017/18 (£K)</th>
<th>2018/19 (£K)</th>
<th>2019/20 (£K)</th>
<th>2020/21 (£K)</th>
<th>2021/22 (£K)</th>
<th>Total (£K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity, children and young people services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s and Young Persons Services</td>
<td>£0</td>
<td>£0</td>
<td>£300</td>
<td>£50</td>
<td>£0</td>
<td>£350</td>
</tr>
<tr>
<td>SCBU Refurbishment</td>
<td>£0</td>
<td>£0</td>
<td>£50</td>
<td>£1,000</td>
<td>£0</td>
<td>£1,050</td>
</tr>
<tr>
<td>Total for Strategy</td>
<td>£0</td>
<td>£0</td>
<td>£350</td>
<td>£1,050</td>
<td>£0</td>
<td>£1,400</td>
</tr>
<tr>
<td>Elective care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy expansion and new Decontamination Unit</td>
<td>£0</td>
<td>£2,000</td>
<td>£250</td>
<td>£500</td>
<td>£500</td>
<td>£3250</td>
</tr>
<tr>
<td>Orthotics - Redevelop vacant areas in Physiotherapy for Orthotics including Physiotherapy enabling works</td>
<td>£0</td>
<td>£0</td>
<td>£250</td>
<td>£500</td>
<td>£500</td>
<td>£500</td>
</tr>
<tr>
<td>Theatre processes and</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Description</td>
<td>£0</td>
<td>£0</td>
<td>£25</td>
<td>£0</td>
<td>£0</td>
<td>£25</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Paediatric Day Surgery</td>
<td>£0</td>
<td>£0</td>
<td>£25</td>
<td>£0</td>
<td>£0</td>
<td>£25</td>
</tr>
<tr>
<td>Ophthalmology Co-location/re-location of Services (Feasibility Study)</td>
<td>£0</td>
<td>£0</td>
<td>£10</td>
<td>£0</td>
<td>£0</td>
<td>£10</td>
</tr>
<tr>
<td>Fracture Clinic</td>
<td>£0</td>
<td>£0</td>
<td>£10</td>
<td>£0</td>
<td>£0</td>
<td>£10</td>
</tr>
<tr>
<td>Relocate Greenoaks services and demolition of building</td>
<td>£0</td>
<td>£1,500</td>
<td>£50</td>
<td>£0</td>
<td>£0</td>
<td>£1,550</td>
</tr>
<tr>
<td>Dermatology Reconfiguration</td>
<td>£0</td>
<td>£0</td>
<td>£10</td>
<td>£0</td>
<td>£0</td>
<td>£10</td>
</tr>
<tr>
<td>Diabetes Centre Reconfiguration (Feasibility Study)</td>
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### Five year capital plan

#### 9.0 Five year capital plan

The strategy proposes a number of changes and schemes to support the overall Trust strategy and, subject to further planning work and where developments are advocated, these will be subject to individual or collective business cases for approval.

This Estates strategy is intended to be dynamic and will be updated as required to reflect any changes in the healthcare landscape or emerging priorities the Trust may determine and remains sufficiently flexible to respond to change.

The Estates Strategy will be a valuable tool to support the delivery of aligned approaches for healthcare efficiency, in line with the objectives of the Five Year Forward View, STP and PLACE plans.

#### Board action required:

For approval

Chris Holt  
Director of Strategy and Transformation  
Date: September 2017

---

Note: Theatre 11 funded from 17/18 Estates backlog maintenance allocation.

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### Integrated Performance Dashboard (September 2017)

#### Top Achievements
- C. diff year to date
  - The rolling 12 month number of C. diff cases has been reported at 17. However behind this improvement is only 2 cases within the last 6 months (both in July). Continuation at this trend would correspond with one of the lowest rate of infections in all NHS hospitals.
- Harm Free Care
  - Following previous escalations TRFT harm free care score has significantly improved. This improvement predominantly relates to a reduction in pressure ulcers in community settings.

#### Worst Achievements
- Sickness Rates
  - In month sickness rates for August have remained significantly under threshold at 3.5%. Whilst there is significant seasonal variance in sickness rates this performance is significantly better than previous years and in the national best quartile.
- Diagnostic Waiting Times (DM01)
  - For the month of August there was 1 of over 3000 patients waiting more than 6 weeks for a diagnostic test. The performance over the past 12 months has been up and down. This strong performance has been underpinned by improved forecasting approaches.

### Key Concerns
- **Medication Error Rate**
  - The medication error rate has shown a gradual increase over the past three months. Analysis has shown that this increase is most likely to relate to improved reporting rather than a deterioration in standards.
- **Stroke Unit Access**
  - Whilst many stroke standards have improved over the past few months, an area of decline has been access to the stroke unit with only 50% of cases meeting the 4 hour standard. (See appendix 1 of the IPR for detailed overview of Stroke performance)

### In Month Activity (M5)

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<th>15/16</th>
<th>16/17</th>
<th>Diff. No</th>
<th>Diff. %</th>
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<td>7,725</td>
<td>1,332</td>
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<td>32,293</td>
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### YTD Activity

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### Appendix 1  Stroke Metrics 2017/18

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<th>Nov</th>
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<th>Mar</th>
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<td>% of Stroke patients who spend at least 90% of their time on a stroke unit</td>
<td>&gt;= 80%</td>
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<td>76.9%</td>
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<td>% of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional</td>
<td>&gt;= 60%</td>
<td>88%</td>
<td>77%</td>
<td>91%</td>
<td>89%</td>
<td>73%</td>
<td>88%</td>
<td>88%</td>
<td>97%</td>
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<td>100%</td>
<td>100%</td>
<td>83%</td>
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<td>% of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital</td>
<td>&gt;= 90%</td>
<td>27.0%</td>
<td>47.2%</td>
<td>46.2%</td>
<td>61.0%</td>
<td>50.0%</td>
<td>44%</td>
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<td>Proportion of patients presenting with stroke with AF anti-coagulated on discharge</td>
<td>&gt;= 60%</td>
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<td>Proportion of stroke patients scanned within one hour of hospital arrival</td>
<td>&gt;= 50%</td>
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<tr>
<td>Proportion of stroke patients scanned within 24 hrs of hospital arrival</td>
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<td>97%</td>
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<td>Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke</td>
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<td>Proportion of patients and carers with joint care plans on discharge from hospital</td>
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<td>Proportion of stroke patients that are reviewed six months after leaving hospital</td>
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<td>Proportion of patients supported by a stroke skilled ESD team</td>
<td>&gt;= 40%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients who receive thrombolysis following an acute stroke</td>
<td>&gt;= 11%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- *METRIC* refers to a specific measure or indicator related to stroke metrics.
- *Target* indicates the minimum acceptable percentage for each metric.
- *Apr* to *Mar* represent the months for which the data is provided.
- *YTD 17/18* shows the year-to-date percentage for the year 2017/18.

---

- % of Stroke patients who spend at least 90% of their time on a stroke unit: The target is 80%, with the data showing a range from 69.4% to 76.9% for the specified months, reaching 76.9% YTD 17/18.
- % of non-admitted higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional: The target is 60%, with the data showing a range from 88% to 73% for the specified months, reaching 83% YTD 17/18.
- % of People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital: The target is 90%, with the data showing a range from 27.0% to 50.0% for the specified months, reaching 46.0% YTD 17/18.
- Proportion of patients presenting with stroke with AF anti-coagulated on discharge: The target is 60%, with the data showing 100% for all months, reaching 100% YTD 17/18.
- Proportion of stroke patients scanned within one hour of hospital arrival: The target is 50%, with the data showing a range from 44% to 23.8% for the specified months, reaching 47.9% YTD 17/18.
- Proportion of stroke patients scanned within 24 hrs of hospital arrival: The target is 100%, with the data showing a range from 100% to 100% for the specified months, reaching 98.4% YTD 17/18.
- Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke: The target is 40%, with the data showing 100% for all months, reaching 100% YTD 17/18.
- Proportion of patients and carers with joint care plans on discharge from hospital: The target is 85%, with the data showing a range from 100% to 100% for the specified months, reaching 100% YTD 17/18.
- Proportion of stroke patients that are reviewed six months after leaving hospital: The target is 95%, with the data showing 100% for all months, reaching 100% YTD 17/18.
- Proportion of patients supported by a stroke skilled ESD team: The target is 40%, with the data showing a range from 100% to 100% for the specified months, reaching 100% YTD 17/18.
- % of patients who receive thrombolysis following an acute stroke: The target is 11%, with the data showing a range from 2.70% to 8.90% for the specified months, reaching 3.00% YTD 17/18.
### APPENDIX 2 - Breakdown of 62 day Performance by Tumour Site - Month 4 (July 2017)

<table>
<thead>
<tr>
<th>Tumour Site</th>
<th>62 Day from 2ww</th>
<th>62 day CUG</th>
<th>62 Day Screening</th>
<th>31 Day 1st Treated</th>
<th>31 Day Subsequent Surgery</th>
<th>31 Day Subsequent Drug</th>
<th>31 Day Subsequent Palliative</th>
<th>2WW</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
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<td>Before reallocations</td>
<td>After reallocations</td>
<td>Before reallocations</td>
<td>After reallocations</td>
</tr>
<tr>
<td>Breast</td>
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<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gynaecological</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
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<td>100.0%</td>
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<td>Head and Neck</td>
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<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<td></td>
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<td></td>
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<tr>
<td>Lower Gastrointestinal</td>
<td>70.0%</td>
<td>66.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<tr>
<td>Lung</td>
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<td>100.0%</td>
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<td>84.6%</td>
<td></td>
<td></td>
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<td>Other</td>
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<td></td>
</tr>
<tr>
<td>Sarcoma</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Skin</td>
<td>92.6%</td>
<td>92.6%</td>
<td>86.7%</td>
<td>86.7%</td>
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<td></td>
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<td>Upper Gastrointestinal</td>
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<td>0.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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<td>82.6%</td>
<td>79.2%</td>
<td>90.5%</td>
<td>90.0%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>88.6%</td>
<td>86.8%</td>
<td>93.8%</td>
<td>93.7%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.9%</td>
<td>100.0%</td>
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<tr>
<td>Speciality</td>
<td>Total Admitted</td>
<td>Total Non Admitted</td>
<td>Total Incomplete</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------</td>
<td>----------------</td>
<td>--------------------</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>&lt;18Wks</td>
<td>18Wks+</td>
<td>% &lt;18Wks</td>
<td>&lt;18Wks</td>
<td>18Wks+</td>
<td>% &lt;18Wks</td>
<td>&lt;18Wks</td>
<td>18Wks+</td>
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<td>127</td>
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<td>415</td>
<td>19</td>
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<td>71</td>
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<td>559</td>
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<td>Trauma &amp; Orthopaedics</td>
<td>143</td>
<td>36</td>
<td>79.89%</td>
<td>396</td>
<td>16</td>
<td>96.12%</td>
<td>1376</td>
<td>96</td>
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<td>Ear, Nose &amp; Throat (ENT)</td>
<td>35</td>
<td>20</td>
<td>60.56%</td>
<td>562</td>
<td>26</td>
<td>95.56%</td>
<td>1021</td>
<td>76</td>
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<td>3</td>
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<td>470</td>
<td>19</td>
<td>98.11%</td>
<td>1225</td>
<td>14</td>
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<td>0</td>
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<td>-</td>
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<td>-</td>
<td>0</td>
<td>0</td>
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<td>Plastic Surgery</td>
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<td>0</td>
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<td>0</td>
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<td>Cardiac Surgery</td>
<td>3</td>
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<td>76.00%</td>
<td>112</td>
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<td>24</td>
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<td>582</td>
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<td>746</td>
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<td>100.00%</td>
<td>98</td>
<td>9</td>
<td>99.00%</td>
<td>360</td>
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<td>0</td>
<td>0</td>
<td>-</td>
<td>0</td>
<td>0</td>
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<td>1</td>
<td>0</td>
<td>100.00%</td>
<td>105</td>
<td>2</td>
<td>98.13%</td>
<td>308</td>
<td>2</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>2</td>
<td>0</td>
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<td>84</td>
<td>2</td>
<td>97.67%</td>
<td>192</td>
<td>5</td>
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<td>Gynaecology</td>
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<td>280</td>
<td>16</td>
<td>94.59%</td>
<td>1058</td>
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<tr>
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<td>100.00%</td>
<td>231</td>
<td>7</td>
<td>97.06%</td>
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<td>Total</td>
<td>714</td>
<td>125</td>
<td>51.50%</td>
<td>3614</td>
<td>162</td>
<td>97.31%</td>
<td>9549</td>
<td>463</td>
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</tbody>
</table>

**TARGETS**

- **Admitted:** 90%
- **Non Admitted:** 95%
- **Incomplete:** 92%

---

**Appendix 3 RTT Incompletes August 2017**

- **General Surgery:** 127 (90.07% in <18Wks, 14 in 18Wks+)
- **Urology:** 65 (97.01% in <18Wks, 2 in 18Wks+)
- **Trauma & Orthopaedics:** 143 (79.89% in <18Wks, 36 in 18Wks+)
- **Ear, Nose & Throat (ENT):** 35 (60.56% in <18Wks, 20 in 18Wks+)
- **Ophthalmology:** 157 (98.13% in <18Wks, 3 in 18Wks+)
- **Oral Surgery:** 0 (in <18Wks, 0 in 18Wks+)
- **Neurosurgery:** 0 (in <18Wks, 0 in 18Wks+)
- **Plastic Surgery:** 0 (in <18Wks, 0 in 18Wks+)
- **Cardiac Surgery:** 3 (76.00% in <18Wks, 1 in 18Wks+)
- **General Medicine:** 11 (84.62% in <18Wks, 2 in 18Wks+)
- **Cardiology:** 8 (80.00% in <18Wks, 2 in 18Wks+)
- **Dermatology:** 29 (85.29% in <18Wks, 5 in 18Wks+)
- **Thoracic Medicine:** 8 (100.00% in <18Wks, 0 in 18Wks+)
- **Neurology:** 0 (in <18Wks, 0 in 18Wks+)
- **Rheumatology:** 1 (100.00% in <18Wks, 0 in 18Wks+)
- **Geriatric Medicine:** 2 (100.00% in <18Wks, 0 in 18Wks+)
- **Gynaecology:** 123 (75.46% in <18Wks, 40 in 18Wks+)
- **Other:** 2 (100.00% in <18Wks, 0 in 18Wks+)

**Total:** 714 (51.50% in <18Wks, 125 in 18Wks+)**
### DM01 - Patients Still Waiting at Month End
#### August 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Investigation</th>
<th>&lt;6 weeks</th>
<th>≥ 6 weeks</th>
<th>Performance (%) breaches</th>
<th>Total WL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>Magnetic Resonance Imaging</td>
<td>183</td>
<td>0</td>
<td>0.00%</td>
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</tr>
<tr>
<td></td>
<td>Computed Tomography</td>
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<td></td>
<td>Non-obstetric ultrasound</td>
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<tr>
<td></td>
<td>DEXA Scan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiological Measurement</td>
<td>Audiology - Audiology Assessments</td>
<td>397</td>
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<tr>
<td></td>
<td>Cardiology - echocardiography</td>
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<td>1</td>
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</tr>
<tr>
<td></td>
<td>Cardiology - electrophysiology</td>
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<td></td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>Urodynamic - pressures &amp; flows</td>
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<tr>
<td></td>
<td>Gastroscopy</td>
<td>229</td>
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<tr>
<td></td>
<td>Total</td>
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<td>0.03%</td>
<td>3138</td>
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</table>
Report: Quality Report

Presented by: Ellie Monkhouse, Acting Chief Nurse and Conrad Wareham, Medical Director

Author(s): As above

Strategic Objective: Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Partners: Securing the future together

Regulatory relevance: NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference: BAF: B1, B4, B7
Corporate Risk Register: 3908, 4733, 4174, 4080

Purpose of this paper:
To summarise a set of quality indicators and to provide assurance to the Trust Board. The Quality Report is presented to the Trust Board to complement the information presented in the Integrated Performance Report. A range of quality indicators are included in this report. Over time they may change as the narrative changes to reflect the content of the Integrated Performance Report

Summary of Key Points:
The key points arising from the report are:

- Overall Harm Free Care score is continuing to improve.
- There has been an improvement in complaint response times this month.
- An action plan has been developed to improve access to Policies and Procedures

Board action required: For noting
1.0 Harm Free Care

1.1 The Quality Improvement target for Harm Free Care for the Trust is 95% for 2017/18. We have seen a sustained improvement again for the classic safety thermometer scores for August 2017. The overall score for July was 94.37% (92.7% for July). The breakdown of these scores is Acute - 94.34% and Community - 94.39%

1.2 A review of the data for the community locations has been undertaken with supervised data collection in August. This identified that some harms were incorrectly attributed to the Trust in previous data collections. Support for community teams will continue until we are assured of consistent results being recorded.

1.3 Maternity has seen a slight deterioration this month against a target of 85% for 2017/18. The score for July was 78.26% (81.8% in June) against the national average score of 73.9%. This deterioration in the score is due to the patient’s perception of safety during their pregnancies. The Division have been asked to review these results and the additional actions they will be taking to improve this specific issue. Paediatrics reported a score of 100% against a target of 100%.

2.0 Complaints

2.1 The Trust received 19 formal complaints and 59 concerns. Complaints responded to within the agreed timescale of 30 working days has increased to 41% from 33% in July. There are no red complaints open. Currently there are five cases under investigation with the Parliamentary Health Service Ombudsman (PHSO).

3.0 Friends and Family Test (FFT)

3.1 There has been a noticeable increase in the number of responses captured this month 4,515 compared to 2,838 in July. The inpatient area with the highest response rate was B5 achieving 100%. 2 inpatient areas fell below the 40% response rate ward A1 (39%) and A4 (37%).

3.2 The area with the highest positive score was Community Services achieving 99%, out of 485 responses. The Trust continues to over perform in relation to positive response scores across all areas.

3.3 The Urgent and Emergency Care Centre’s response rate doubled in month achieving 4.5% (2% in July) but they continue to struggle to achieve the 15% national target. Positive score in UECC increased to 97% from 91.4%.

4.0 Nurse Staffing Report

4.1 Nurse staffing was challenging during August due to a combination of unfilled vacancies, annual leave and reduced fill rates for Bank and Agency shifts. Details are shown in Appendix 1.

4.2 A number of actions are currently being undertaken to support areas being most adversely affected and details of impact will be included in October’s report.
5.0 **Review of Policies and Procedures**

5.1 A review has been undertaken of the status of Policies and Procedures. Details are shown in Appendix 4.

6.0 **Looked After Children**

6.1 Progress continues to be made with the completion of Initial Health Assessment appointments within 20 days now at 63%, up from 43% in July. Details are shown in Appendix 3.

7.0 **CQC requirement notice update**

7.1 The Quality Improvement Board monitors the progress made with implementation of the three regulatory actions (Regulation 11 - Need for consent, Regulation 17 - Good governance: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity and Regulation 18 Staffing) allocated to the Trust following the September 2016 Care Quality Commission Inspection, along with the 64 must and should do actions.

7.2 The members of the Quality Improvement Board review the trackers that are completed for the regulations and action plans completed for the must and should do actions and discuss any escalations that need to be made to the Quality Assurance Committee.

7.3 The next meeting of the Quality Improvement Board is to be held on 11 October 2017, and following this an updated position on the actions will be included in the October 2017 Quality Report.

8.0 **Healthcare Associated Infections**

8.1 The hospital acquired C diff trajectory for 2017/18 is 26 cases. Q1 had zero cases.

8.2 There have been no cases reported in August. The two hospital acquired cases reported during July, one of which was internally classed as having a lapse in care, have not yet been externally reviewed by the CCG.

8.3 The hospital acquired MRSA bacteraemia trajectory for 2017/18 is zero and there have been no cases to date. Increased mandatory surveillance and reporting of Gram negative bacteraemia, (E.coli, Klebsiella, Pseudomonas aeruginosa) continues with the aim to reduce avoidable gram negative bacteraemia. The Trust continues to work collaboratively with colleagues from Public Health England and Local Health Protection on any aspects of wider public health such as TB & Legionella.

8.4 Public Health England guidance on Candida auris fungal infection was issued in August and a TRFT local plan to ensure appropriate identification and management of any at risk person admitted to the Trust has been commenced.

9.0 **Medical Staffing Report**

9.1 This is attached in Appendix 5.
10.0 Conclusion

10.1 Improvements have been noted overall in most areas this months with a particularly strong performance on Healthcare Associate Infections. Staff both medical and nursing remains challenging.

Mrs Ellie Monkhouse
Acting Chief Nurse

Dr Conrad Wareham
Medical Director

September 2017
Nurse Staffing Report

1. The headlines for August 2017 are that Registered Nurse (RN) shift fill rates (daytime) were 80.4% compared to 86.2% in July and 90.6% on nights compared with 93%. Healthcare Support Worker (HCSW) fill rates reduced to 103% on days from a position of 105.4% in July and to 97.3% on nights compared with 100.2%.

2. Thirteen in-patient areas had Registered Nurse fill rates (days) below 90%. These were A1, A2, A4, A5, AMU, Neuro Rehab, Community Unit, Stroke Unit, CCU, Critical Care, B4, Keppel and Fitzwilliam. Of these, ten had a day time shift fill rate less than 80% and these were; A1 at 66.7% compared with 73.7% in July, A2 at 76.6% compared with 77.8%, A4 at 61.9% compared with 65.6%, A5 at 58.3% compared with 66.9%, AMU at 72.1% compared with 78% Stroke Unit at 62.7% compared with 78%, Critical Care at 78.3% compared with 81.6%, B4 at 71.8% compared with 85.3%, Fitzwilliam at 73% compared with 82.3% and Keppel at 63.5% compared with 100% in July.

3. Two areas had a fill rate below 80% on nights; these were Keppel at 68.8% and CCU at 79.6%. There were 5 shifts in the month with over 50% of RNs on duty being within the 12 month preceptorship period compared with 14 shifts in July. There has been an increase in the percentage of RN flexible staffing (internal bank) in the Divisions of Surgery and Medicine and a reduction in Family Health during August. There has been an overall increase in RN agency usage in August but no HCSW agency usage. There was an increase in the percentage of shifts not staffed to plan from 26.06% in July to 30.65% in August.

4. There were 3 internal never event shifts relating to 1 RN on duty:

   Wharncliffe 2nd midwife redeployed to Labour ward. Supported by Maternity Support worker and a Nursery Nurse until RSCN from Children’s Ward attended.

   Ward A7 Nurse moved by Site Manager to cover Wharncliffe Ward.

   Ward A1 where there was only 1 Registered nurse on duty, (this related to 1 RN and 1 RN on a development plan being left on the ward.

5. In the community there was a deficit of 6.7% of nurses against plan, which represents a worse position as compared with July and can be accounted for by the summer holiday and a high percentage of sickness at 4.2%.

6. Ten areas Care Hours per Patient Day (CHpPD) are lower than the national best practice wards, these are AMU, A1, A4, A5, A7, CCU, Fitzwilliam, Keppel, B4 and B5. With the exception of A7 this is due to the lower fill rate as a result of vacancies in these areas. It is understood that A7 is related to the inclusion of the planned investigations unit.

7. 39 newly qualified nurses are due to commence employment in the Trust in September / October and a further recruitment open day occurred on 12 August, particularly aimed at nurses due to qualify in March 2018. 25 further posts were offered at this event.
E roster reviews are currently taking place with Ward Managers, Matrons and Heads of Nursing to ensure roster templates are set correctly.

The Safer Nursing Care Tool was deployed during May 2017 in all in-patient wards and the ward establishment reviews took place during August.

The Divisions of Medicine and Surgery are also currently planning to reconfigure some of the wards which is likely to impact upon ward establishments in these areas, therefore no changes to establishments were proposed at this time. Following the establishment reviews, the Acting Chief Nurse and Director of Workforce met with each divisional leadership team during August and reviewed the outputs prior to final sign off the establishment plans.
### August 2017

**Only complete sites your organisation is accountable for**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Main 2 Specialties on each ward</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Average fill rate - registered midwives (%)</th>
<th>Average fill rate - care staff (%)</th>
<th>Average fill rate - registered midwives (%)</th>
<th>Average fill rate - care staff (%)</th>
<th>Cumulative count over the month of patients at 23:59 each day</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>320 - CARDIOLOGY</td>
<td>300 - GENERAL MEDICINE</td>
<td>1782.5</td>
<td>1168.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1103.5</td>
<td>1126.5</td>
<td>66.7%</td>
<td>103.0%</td>
<td>96.8%</td>
<td>103.2%</td>
<td>3206.5</td>
</tr>
<tr>
<td>A2</td>
<td>300 - RESPIRATORY MEDICINE</td>
<td>300 - GENERAL MEDICINE</td>
<td>1782.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>66.7%</td>
<td>103.0%</td>
<td>96.8%</td>
<td>103.2%</td>
<td>3208.5</td>
</tr>
<tr>
<td>A3</td>
<td>300 - GENERAL MEDICINE</td>
<td>300 - GENERAL MEDICINE</td>
<td>1782.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>1069.5</td>
<td>66.7%</td>
<td>103.0%</td>
<td>96.8%</td>
<td>103.2%</td>
<td>3208.5</td>
</tr>
</tbody>
</table>

**Care Hours Per Patient Day (CHPPD)**

<table>
<thead>
<tr>
<th>Day</th>
<th>Night</th>
<th>Average fill rate - registered midwives (%)</th>
<th>Average fill rate - care staff (%)</th>
<th>Average fill rate - registered midwives (%)</th>
<th>Average fill rate - care staff (%)</th>
<th>Cumulative count over the month of patients at 23:59 each day</th>
<th>Registered midwives/nurses</th>
<th>Care Staff</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>90.6%</td>
<td>103.0%</td>
<td>96.8%</td>
<td>103.2%</td>
<td>3206.5</td>
<td>3269.5</td>
<td>3206.5</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>90.6%</td>
<td>103.0%</td>
<td>96.8%</td>
<td>103.2%</td>
<td>3206.5</td>
<td>3269.5</td>
<td>3206.5</td>
<td></td>
</tr>
</tbody>
</table>

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**Note:** The table above provides detailed information on care hours and staffing levels for various wards at Rotherham District General Hospital for the month of August 2017. It includes data on midwives/nurses and care staff, along with their fill rates and cumulative patient counts. The data is organized by ward, with columns for day and night shifts, and metrics for registered midwives/nurses, care staff, and overall staffing. The table also highlights the care hours per patient day (CHPPD) for each day, showing the percentage of registered midwives and care staff. The cumulative count over the month of patients at 23:59 each day is also provided, along with the registered midwives/nurses and care staff counts for each day.
Looked After Children

Synopsis of compliance year to date:

The increase in compliance for August has been supported by a change in practice relating to the completion of the outline Health Recommendations section of the BAAF paperwork during the Initial Health Assessment appointment.

A second multi-professional task and finish group meeting was held in August including Health, CCG and Social Care. At this meeting it was recognised that the change in practice regarding outline Health Recommendations was working well albeit this was only 2 weeks since implementation.

Work continues with “refusers”, young people have a choice whether to have the assessment and the target does not account for this. Engagement work continues with young people to discuss the assessment and build relationships with them before they are due to see the doctor.

The Trust work closely with Social Care colleagues in the validation of data regarding the number of outstanding initial and review health assessments. It has been agreed that the following information will be provided by RMBC to TRFT:

Number of Children Became Looked After
Number of Children Ceased to be Looked After
Number of Outstanding Initial Health Assessments
Compliance Rate against 20 Working Day Target

Initially, this information will be provided on a weekly basis to allow for on-going validation in order to address any discrepancies immediately.

There is to be a region-wide meeting in September 2017 to develop a standard data reporting system to ensure that when discussing data we are comparing like with like which is not currently the case.
Review of Policies and Procedures

The CQC September 2016 inspection identified a number of issues with policies and procedures which led to regulatory actions being given to the Trust. Whilst the issues have been resolved in the relevant areas that were mentioned in the CQC report, they are actually more systematic throughout the Trust. Therefore, an action plan has been developed to address it. However, it is recognised that the Acting Chief Nurse and Quality Governance, Compliance and Risk Manager (DRG Chair) inherited the issues and have been working to address them after it came into their remit.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Issue</th>
<th>Action</th>
<th>Date and Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backlog</td>
<td>There are currently 22 documents which have been approved by the Document Ratification Group and have not been uploaded to Insite.</td>
<td>The documents will be uploaded in their current format (with a caveat) by 30th September 2017. By the 30th November 2017 the 22 plus a previous 22 which were uploaded in their current format will be reviewed and any formatting issues resolved and reloaded.</td>
<td>30th September 2017. 30th November 2017 Quality Governance, Compliance and Risk Manager</td>
</tr>
<tr>
<td></td>
<td>There are currently 7 documents which have been presented to the Document Ratification Group and were not approved and so require further work and representing.</td>
<td>The queries will be resolved with the author and they will be uploaded by 31st October 2017.</td>
<td>31st October 2017 Quality Governance, Compliance and Risk Manager</td>
</tr>
<tr>
<td>Out of Date Policies and Procedures</td>
<td>There are a number of out of date policies and procedures which require reviewing.</td>
<td>Generic communication through the weekly email bulletin and Governance forums will remind authors of the need to ensure that their documents are up to date. Reminders will be sent to authors of documents that are out to date to ensure that they are reviewed or an extension is obtained.</td>
<td>Monthly basis until March 2018. Quality Governance, Compliance and Risk Manager 30th November 2017 Quality Governance, Compliance and Risk Manager</td>
</tr>
<tr>
<td>Document Ratification Process</td>
<td>Concerns have been raised about the process for Document Ratification, including:</td>
<td>The Designated Approving Committees / Groups (who approve the document and recommend for approval at DRG) are not always undertaking a thorough review of the documents and so therefore when they are presented to DRG, they are not approved.</td>
<td>30th November 2017</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td>The Terms of Reference for all Designated Approving Committees / Groups will be obtained and reviewed to ensure that they detail the role as an approving Committee/Group.</td>
<td>The DRG Chair will meet with the Chair of the Designated Approving Committees / Groups to ensure that they understand the role of the Committee/Group.</td>
<td>30th November 2017</td>
</tr>
<tr>
<td></td>
<td>The Documents that are sent to the DRG for approval will be monitored to identify any Designated Approving Committees / Groups who require further support.</td>
<td>Ongoing</td>
<td>Quality Governance, Compliance and Risk Manager</td>
</tr>
<tr>
<td>Staff within the Trust are not aware of the process for Document Ratification</td>
<td>The Head of Governance will develop a Trust Committee Structure and Approval Process document, which will inform staff of the document ratification process.</td>
<td>31st December 2017</td>
<td>Head of Governance</td>
</tr>
<tr>
<td></td>
<td>Workshops will be held across the Trust Sites to de-mystify the process of writing, consulting upon and ratifying a policy, guideline or SOP.</td>
<td>31st January 2018</td>
<td>Quality Governance, Compliance and Risk Manager</td>
</tr>
</tbody>
</table>
| SharePoint | Staff cannot access approved documents on Insite | Insite is moving to SharePoint and this will enable easier storing and searching for documents. However, clarity on when this will occur is not known. The DRG Chair will obtain a timeline for rolling out of SharePoint. | 30\textsuperscript{th} September 2017. 
Quality Governance, Compliance and Risk Manager |
| --- | --- | --- | --- |
| The Policy for the Development, Monitoring and Review of Trust Document is out of date. An extension has been obtained and an updated document presented to Board however it hasn't been approved. | The Director of Corporate Affairs to finalise the policy. | Deadline TBC 
The Director of Corporate Affairs | 
| Three will be held prior to the deadline and then a number set up following publication of the updated policy. | | Compliance and Risk Manager |
Medical Staffing Report

Introduction & Background

1.1 The Trust has worked hard in recent months and years to recruit to its vacancies. As a result processes and practices are now in place which are working well for recruiting to the majority of roles. However, there are some still some roles which are proving very difficult to recruit to. The Trust chose to focus on recruiting to the 30 most needed of these roles, referring to them as the “Top 30”.

1.2 Divisions were requested to identify the top 30 critical posts to allow for the concentration of recruitment efforts.

1.3 An initial exercise identified 17 medical posts at Consultant level, shown below, but this has now expanded and is detailed in Paragraph 2.2:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine Consultant</td>
<td>2</td>
</tr>
<tr>
<td>Acute Medicine Consultant</td>
<td>2</td>
</tr>
<tr>
<td>Consultant Gastroenterologist</td>
<td>2</td>
</tr>
<tr>
<td>HCOP Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Histopathologist</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Radiologist</td>
<td>2</td>
</tr>
<tr>
<td>Consultant Dermatologist</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Paediatrician</td>
<td>1</td>
</tr>
<tr>
<td>Consultant Cardiologist</td>
<td>2</td>
</tr>
<tr>
<td>Consultant Urologist</td>
<td>2</td>
</tr>
<tr>
<td>Neuro-Rehab Consultant</td>
<td>1</td>
</tr>
</tbody>
</table>

1.4 In addition to these there were also a number of non-medical posts which are very hard to fill. This initial list provided by the Recruitment Manager was based on local intelligence and comprised:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>4.75</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>2.25</td>
</tr>
</tbody>
</table>
Physiotherapist Specialist Practitioner | 1.18
Radiographer - Diagnostic             | 3.7  
Biomedical Scientist                 | 2.25 
Clinical Coder                       | 1.7  

1.5 The posts detailed at 1.4 have now been recruited to and are no longer the focus of a targeted effort. SWC requested a further update on medical recruitment, so the paper will now concentrate on this area along with future monthly updates.

2. Medical Recruitment Update
2.1 The Trust continues to have a consultant vacancy rate of 20%; however these are concentrated in specific specialties with premium spend agency locums covering the vacant posts, particularly across Medicine and the ED.
2.2 An update is provided below for consultant posts:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Est.</th>
<th>Vac.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>HCOP</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Histopathology</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Radiology</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Dermatology</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Urology</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Neuro-Rehab</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Stroke</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Microbiology</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

2.3 The Trust will have a stand this year at the BMJ Careers Fair on 20 & 21 Oct 17; displays are being discussed and literature will be produced in liaison with the Communications Team. Medical Workforce will attend both days as will the MD along with other clinicians and service managers.

2.4 The implementation of Trust Associate Specialist grades continues and a paper was agreed at TMC and further approved by Remuneration Committee.

3. **Medical Red Flag Shifts**

3.1 Medical Red flag shifts for July and August are shown below. There is no actual harm incidents reported with any of these issues.
September 2017
BOARD MEETING: 26 September 2017

Agenda item: 344/17(b)

Report: Operational Performance Report

Presented by: Maxine Dennis, Director of Operations
Author: Maxine Dennis, Director of Operations

Strategic Objective:
- Patients: Excellence in healthcare
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations
- Partners: Securing the future together

Regulatory relevance:
- NHSI: Licence Condition FT4
- CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
- BAF: B1, B2, B4
- Corporate Risk Register: As appropriate.

Purpose of this paper:

This paper provides, for each key operational indicator, an overview of performance in August 2017, summarising headline progress and actions being taken to address on-going issues.

Summary of Key Points:

Sustainability and Transformation Standards

- Emergency 4-hour Access target – August 2017 position: 82.4% (Now reported as all attendances). The year to date position is 85.42% (as at 17 September 2017)
- Diagnostics (DMO1) – DMO1 for August 2017 has been achieved at 0.03% against the 1% threshold (equates to only 1 breach)
- 18 week RTT incomplete pathway – target has been achieved for August 2017 at 95.2%
- The Rotherham Cancer 62 Day position for July 2017 is 87.1% against the 85% compliance target. However, there is a risk that after re-allocation of complex tertiary pathway breaches, this may result in performance below the 85% threshold

Other Operational Indicators/Information

- Rotherham A&E Delivery Board Winter Plan approved – Rotherham NHS Foundation Trust Winter Planning Group established

Board action required:

For noting
1.0 Introduction

1.1. This paper provides, for key operational indicators, an overview of performance in August 2017, summarising headline progress and actions being taken to address areas of concern and deliver continuous improvements.

2.0 Four-hour emergency access target

2.1. Performance for August 2017 against the 4-hour access target was 82.4%. The year to date position is 85.42% (as at 17 September 2017).

2.2. Whilst performance continues to fall below the performance required, there has been a small improvement in month (July – 81.15%). In addition, the September 2017 performance to date (as at 17 September 2017) is 84.69%.

2.3. The Recovery Action Plan continues to be monitored and measured through the weekly 4-hour access performance meeting and the Executive Team are continuing to meet with the UECC Leadership team on a fortnightly basis to drive and support the improvement required internal to the UECC.

2.4. The Meditech Workshop requested by the UECC leadership team to review the processes in Meditech, which may be impacting on slowing down the flow through the UECC, took place on 14 September 2017. It was well attended by both IT and UECC clinical teams. The output from the workshop resulted in a number of actions that will improve the system’s responsiveness required for it to support UECC processes. These actions will be monitored as part of the overarching 4-Hour Access Recovery Plan.

2.5. The breach analysis shows that the majority of breaches remain delays to be seen by a doctor – this is predominantly in the “out of hour periods” i.e. evenings and weekends when there remains a significant reliance on locum middle grade doctors and locum consultants. However, there have also been periods in August when there has been pressure on bed capacity – the latter resulting in intermittent periods when additional surge beds have had to be provided. Whilst length of stay remains relatively good, there has been an increase in the number of delayed transfers of care.

2.6. The Trust is continuing to work with the Emergency Care Intensive Support Team (ECIP) in relation to supporting an improvement in performance. On 23 August 2017 one of the ECIP clinical leads (who is an ED consultant) spent a day working in the UECC with the team to offer support and observe the ways of working. Whilst there were a number of recommendations made, there were no major concerns flagged and comment was made about a number of good practises observed. The recommendations made have been included in the Recovery Action Plan update. It was agreed to continue to work with ECIP in other areas where support from external experts will enhance improvement.
3.0 **Cancer**

3.1 The Rotherham 62-day cancer position for July 2017 is 87.1% against the 85% compliance target.

3.2 However, there is a risk that after re-allocation of complex tertiary pathway breaches this may result (by the end of Quarter 2) in performance below the 85% threshold.

4.0 **18 week RTT Incomplete**

4.1 The final validated position for August 2017 is 95.2% against the 18 week RTT incomplete target of 92%. This represents a continued strong operational performance against this performance metric.

4.2 The forecast position for September 2017 is currently at 93.5% and there is no deterioration in the 18 week RTT incomplete performance forecast through October 2017.

5.0 **6 week wait diagnostic tests**

5.1 The Trust has achieved the DMO1 1% threshold for patients waiting 6 weeks or longer for diagnostic tests. Trust performance for August 2017 was 0.03% - this equates to one breach only.

5.2 The forecast position suggests that DMO1 will continue to be achieved in the month of September 2017.

6.0 **General Operational Updates**

6.1 Performance against the 4-hour access standard remains the Trust’s main concern specific to operational delivery and performance indicators. The Recovery Action Plan is making progress, however the outstanding risk that continues to impact on performance remains the fragility of the senior medical staff rota and the reliance on locum medical staff.

6.2 The Trust-wide 4-Hour Access Summit taking place on 29 September 2017 will engage and challenge all Divisional teams, but in particular clinical teams, to identify actions and solutions that will drive a system response to improving the Trust’s 4-hour access performance. There has been a positive response to the event from all Divisions with a good clinical commitment to attend. Where performance has improved nationally, it has been in Trust’s that have a more proactive inward facing response to the challenges of urgent care.

6.3 The system-wide A&E Delivery Board Winter Plan 2017/2018 has been approved at the September 2017 A&E Delivery Board. The Trust has made significant contributions to this strategic plan. The Trust specific Winter Plan is well developed and a Winter Planning Group has been established to both continue to develop the plan and drive implementation. The detailed analysis on the anticipated capacity and demand over the winter period has been completed, which will further influence specific detailed planning for peak levels of activity.
6.4 The work to develop and establish an Integrated Discharge Team that will support the priorities in the wider action plan is moving forward. The first phase to co-locate teams is underway. In addition, the new ways of working that include a consistent reporting of DTOCs, a trusted assessor approach and a home first approach are all being progressed through the project team leading on this as part of the Trust Transformation Programme. The measure of success will be a reduction in the number of delayed transfers of care and this will be monitored closely over the coming weeks.

6.5 The refurbishment of Theatre 11 has been completed and the Theatre re-opened on 29 August 2017. This provides a state of the art high specification operating theatre with a laminar flow that will facilitate more orthopaedic operating capacity and flexibility. The impact of the closure of the Theatre and the re-provision of lost Theatre lists is currently being assessed as part of overall Theatre Utilisation and activity assessments.

7.0 Conclusion

7.1 Performance against the 4 hour access standard in August 2017 continued to be significantly lower than the 95% standard required. The wider improvement action continues to be monitored through the weekly 4-hour access meeting and through a fortnightly meeting with the Trust Executive Team.

7.2 Performance against DMO1 threshold target in month for August 2017 has continued to improve with performance at 0.03% against the 1% threshold – this was actually one breach only during the month.

7.3 The Rotherham Cancer 62-day performance remains strong. However, there is a risk that the re-allocation of complex tertiary pathway breaches may have an adverse impact on final Quarter 2 position.

7.4 Trust performance against the 18-week incomplete target for the month continues to perform well and the forecast position for September 2017 is that this positive performance will continue through September and October 2017.

7.5 The strategic system-wide A&E Delivery Board Winter Plan 2017/2018 has been approved and the Trust specific plans and actions are well developed with a Trust Winter Planning Group established.

M Dennis
Director of Operations
September 2017
Report: Workforce Report

Presented by: Cheryl Clements, Director of Workforce
Author(s): Cheryl Clements, Director of Workforce

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B5, B6, B7
Corporate Risk Register: 2978, 2979, 4762, 4959, 3520, 3908, 5226, 4877, 5068, 5226, 4516, 2978, 2979, 4877, 4935, 4959, 3520, 3908

Purpose of this paper:

This paper provides the Board of Directors with an update on key workforce issues.

Summary of Key Points:

- Staff in post in August 2017 is 3678.54 WTE, a decrease of 26.91 WTE compared to July 2017.
- Rolling 12 month’s sickness absence is 4.34%, a decrease of 0.09% compared to July 2017.
- In month sickness absence has decreased from 3.87% to 3.53% for August 2017 and remains under the 3.95% target.
- Appraisal compliance has risen to 89%, this is a 3% increase compared with previous month but is below Trust target of 95%.
- The Mandatory and Statutory Training compliance rate for core subjects has reached the Trust target of 85%.
- Apprenticeship activity has increased over the last few months and the Trust expects 40 new apprenticeships to have commenced in the organisation by the end of September 2017. The target is 100 this financial year.
- The Trust remains over the NHSi trajectory on Agency spend.

Board action required: For Noting
1.0 **Workforce Strategy and Plan**

1.1 The Workforce Strategy and Plan supports the delivery of our Trust Five Year Strategy and reflects the agreed workforce objectives.

2.0 **Workforce Transformation Programme**

2.1 The Workforce Transformation Programme is in the early stages of implementation. The Programme aims to deliver workforce transformation and consists of 5 key projects:

- **Allied Health Professionals (AHP) Project** – led by General Manager for Clinical Support Services. This project seeks to maximise use of e-Rostering and review AHP skill mix.
- **Community Nursing Project** – led by the Acting Chief Nurse seeks to maximise scheduling efficiency and review skill mix.
- **Nursing Projects** – led by the Acting Chief Nurse, seeks to ensure Clinical Nurse Specialist productivity and income capture, reduce bank and agency spend, maximise use of e-Rostering and review skill mix.
- **Medical Staffing Project** – led by the Medical Director, seeks to improve job planning and reduce agency and locum expenditure.
- **Corporate and Administration and Clerical (A&C) Project** – led by the Director of Finance, seeks to review A&C roles Trust wide and Corporate Departments expenditure.

2.2 Each project is in the process of agreeing project governance arrangements and once these have been finalised detailed plans and deliverables, along with relevant financial savings will be available.

2.3 Each project is working closely with the Divisions as the majority of the programme deliverables will be at Divisional level as part of the Divisional cost improvement plans and ward/service reconfiguration projects.

3.0 **Recruitment and Retention**

3.1 Turnover in August 2017 is 0.55% (99.45% retention), which is a reduction of 0.48% against August 2016 (98.97% retention).

3.2 During the period September 2016 to August 2017 staff in post for the Trust has increased by 144.71 WTE.

3.3 There are currently 100 substantive posts (65 newly qualified) and 7 bank posts being processed by the Recruitment Team. 91 newly qualified staff nurses were offered posts in the Trust in March; 34 nursing colleagues are due to commence in September 2017.

4.0 **Sickness Absence**

4.1 The Trust’s sickness absence for August 2017 is 3.53%, which remains below the 3.95% target and it represents a slight decrease of 0.34% (3.87%) from the previous month.

4.2 Rolling 12 month’s sickness absence is 4.34%, a decrease of 0.09% compared to July 2017.
5.0 **MAST Training**

5.1 The Trust core MaST compliance has reached the Trust target of 85%. Separate compliance reports for specific job role training have also been developed for Divisions.

5.2 **Table - Mandatory and Statutory Core training compliance by Division at 14 September 2017.**

<table>
<thead>
<tr>
<th>Division</th>
<th>Conflict Resolution</th>
<th>Dementia Awareness - No Renewal</th>
<th>Equality &amp; Diversity</th>
<th>Fire Safety - 1 Year</th>
<th>Hand Hygiene - 1 Year</th>
<th>Information Governance - 1 Year</th>
<th>Prevent WRAP - No Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td>165 Clinical Support Services</td>
<td>91.56%</td>
<td>93.53%</td>
<td>93.41%</td>
<td>85.90%</td>
<td>76.18%</td>
<td>85.20%</td>
<td>97.92%</td>
</tr>
<tr>
<td>165 Corporate Operations</td>
<td>90.12%</td>
<td>94.22%</td>
<td>89.88%</td>
<td>89.88%</td>
<td>92.29%</td>
<td>85.06%</td>
<td>84.10%</td>
</tr>
<tr>
<td>165 Corporate Services</td>
<td>90.39%</td>
<td>92.53%</td>
<td>93.59%</td>
<td>85.41%</td>
<td>80.07%</td>
<td>82.21%</td>
<td>98.22%</td>
</tr>
<tr>
<td>165 Family Health</td>
<td>84.74%</td>
<td>91.28%</td>
<td>86.76%</td>
<td>79.75%</td>
<td>78.04%</td>
<td>79.44%</td>
<td>92.06%</td>
</tr>
<tr>
<td>165 Medicine</td>
<td>78.26%</td>
<td>85.84%</td>
<td>81.83%</td>
<td>72.51%</td>
<td>71.96%</td>
<td>76.80%</td>
<td>81.37%</td>
</tr>
<tr>
<td>165 Surgery</td>
<td>82.14%</td>
<td>87.49%</td>
<td>89.31%</td>
<td>78.27%</td>
<td>72.01%</td>
<td>77.36%</td>
<td>88.28%</td>
</tr>
</tbody>
</table>

6.0 **Leadership, Culture and Engagement**

6.1 The next three programmes of the band 7 LEAD programme are being advertised for September, October and November which means by the end of November approximately 160 colleagues will have been through the programme.

6.2 Apprenticeship activity has increased in the last few months and the Trust anticipate 40 new apprenticeships commencing by the end of September.

6.3 Appraisal/PDR compliance has risen to 89% for the Trust, this is 3% increase compared with previous month.

Cheryl Clements  
Director of Workforce  
September 2017
Report: Finance Report

Presented by: Simon Sheppard, Director of Finance
Author(s): As above

Strategic Objective:
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations
- Partners: Securing the future together

Regulatory relevance:
- NHSI: Licence Condition FT4 / Single Oversight Framework
- CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
- BAF: B9, B10
- Corporate Risk Register: 4379, 4380, 4629, 4363, 4516

Purpose of this paper:
This paper provides the Board of Directors with an update on performance against the Trust’s key financial duties, namely:

- Delivery against the planned income and expenditure plan in month (August) and year to date (April – August 2017)
- Cost Improvement Programme Performance
- Capital Expenditure
- Cash Position
- Continuity of Service Risk Rating

Summary of Key Points:

- The Trust is significantly off plan in month and year to date.
- Financial recovery plans have been produced to address the financial challenge. Progress against these actions is being monitored on a weekly basis via the Executive team and General Manager meeting.
- Cash continues to be managed on a weekly basis with the Income & Expenditure position continuing to challenge cash management.
1. **Income & Expenditure (in month and ytd)**

Month 5 performance shows a year to date performance which is £3,682K worse than plan - a deficit of £14,989K compared to a planned deficit of £11,307K. In month performance which is £1,352K worse than plan – a deficit of £2,006K compared to a planned deficit of £655K

The 2 key factors for the year to date position are:

- **Activity** – patient care activity and income was significantly below the plan for August and below the forecast levels. The Director of Finance with support of the Director of Informatics, plus external expertise is leading a piece of work to validate the activity levels across 4 main categories, each with a senior lead;
  - Capturing of activity
  - Coding/Pricing of Activity
  - System change control
  - Timeliness of coding

- **Pay Costs** – pay costs continue to be above budget in month and the run rate remains unchanged. To support the delivery of the finance plan and cost improvement programme the pay costs need to reduce in line with the financial delivery plans.

Pay costs, as well as a driver for the August position, are the main contributing factor to the adverse year to date position. It is vital that the pay recovery schemes as agreed with the Divisions and Directorates are delivered to value and profile.

These pay plans are an integral element of the Divisional and Directorate comprehensive financial recovery plans. This plan is at a Divisional level which identifies specific actions required, profiled monthly with lead officers. The Director of Finance and Executive team have been working closely with Divisions to support and manage these recovery plans.

The recovery plans have been provided to the Finance & Performance Committee and are being monitored and overseen on a weekly basis by the Executive Team, supported by “flash reports” on pay costs and activity levels to give early visibility on operational implementation. In addition, dedicated senior finance support from internal resources has been focused solely on supporting the recovery plans and cost improvement programmes.

<table>
<thead>
<tr>
<th>In Month</th>
<th>Year To Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£000s</strong></td>
<td><strong>£000s</strong></td>
</tr>
<tr>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>17,776</td>
<td>17,308</td>
</tr>
<tr>
<td>867</td>
<td>969</td>
</tr>
<tr>
<td>556</td>
<td>561</td>
</tr>
<tr>
<td>1,103</td>
<td>981</td>
</tr>
<tr>
<td>20,302</td>
<td>19,838</td>
</tr>
<tr>
<td>14,008</td>
<td>14,229</td>
</tr>
<tr>
<td>6,125</td>
<td>6,868</td>
</tr>
<tr>
<td>20,133</td>
<td>21,097</td>
</tr>
<tr>
<td>168</td>
<td>(1,259)</td>
</tr>
<tr>
<td>524</td>
<td>746</td>
</tr>
<tr>
<td>(655)</td>
<td>(2,006)</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(655)</td>
<td>(2,006)</td>
</tr>
</tbody>
</table>
2. Cost Improvement Programme

- The Trust has a cost improvement (CIPs) target for 2017/18 of £8.5m.
- CIPs delivery at the end of August is off track, with the year-end forecast also showing an adverse position.

<table>
<thead>
<tr>
<th>Division</th>
<th>YTD Revised Plan</th>
<th>YTD Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>1,105</td>
<td>867</td>
<td>-238</td>
</tr>
<tr>
<td>Medicine</td>
<td>498</td>
<td>495</td>
<td>-3</td>
</tr>
<tr>
<td>Family Health</td>
<td>476</td>
<td>475</td>
<td>-2</td>
</tr>
<tr>
<td>CSS</td>
<td>756</td>
<td>546</td>
<td>-210</td>
</tr>
<tr>
<td>Corporate</td>
<td>420</td>
<td>329</td>
<td>-91</td>
</tr>
<tr>
<td>Total</td>
<td>3,255</td>
<td>2,711</td>
<td>-544</td>
</tr>
</tbody>
</table>

- The CIP Delivery Board is now ensuring fortnightly focus on the Cost Improvement Programme across the 5 Divisions and Trust wide workstreams
- More schemes are needed to close the gap in year and recurrently and mitigate the risks to delivery. This will be driven and monitored by the CIP Delivery Board which has the full involvement of the General Managers and key corporate functions

3. Capital

- Actual expenditure incurred during August 2017 of £1,550K compared to a planned budget of £249K representing an over-spend of £1,302K mainly as a consequence of the final payments relating to the Urgent & Emergency Care Centre.
- Cumulative expenditure incurred for the first five months of the financial year equates to £2,778K compared to a cumulative budget of £1,299K representing an over-spend of £1,479K.

A forecast out-turn for the full financial year of £3,741K, which represents an over-spend of £468K against the annual budget of £3,273K

4. Cash

- The trust ended August 2017 with a cash balance of £1.562m (£1.703m in July) compared to a planned level of £1.354m which is an £0.208m favourable variance. The cash balance does include the monthly receipt of deficit funding and further working capital support.
- The Income and Expenditure performance continues to provide a challenging position in regards to cash.
5. **Key Metrics**

<table>
<thead>
<tr>
<th>Financial Duty</th>
<th>August YTD Plan £000s</th>
<th>August YTD Actual £000s</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Deficit excluding Impairment</td>
<td>(6,307)</td>
<td>(9,989)</td>
<td>R</td>
</tr>
<tr>
<td>Cash</td>
<td>1,354</td>
<td>1,547</td>
<td>R</td>
</tr>
<tr>
<td>Achieving the Capital Plan</td>
<td>1,299</td>
<td>2,778</td>
<td>R</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric</th>
<th>Weight</th>
<th>August Actual</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuity of Services</strong></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Balance Sheet Sustainability</td>
<td>20%</td>
<td>4</td>
<td>2.5x</td>
</tr>
<tr>
<td>Capital Servicing Capacity (Times)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Liquidity</strong></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Liquidity Days</td>
<td>20%</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Financial Efficiency</strong></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Underlying Performance</td>
<td>20%</td>
<td>4</td>
<td>0%</td>
</tr>
<tr>
<td>I&amp;E Margin</td>
<td></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Variance from Plan</td>
<td></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Variance in I&amp;E Margin as a % of Income</td>
<td>20%</td>
<td>4</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Agency</strong></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Agency spend against agency ceiling</td>
<td>20%</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Overall Financial Sustainability Risk Rating</td>
<td>100%</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

**Board action required:**

For noting
Report: Mortality Report
Presented by: Dr C Wareham, Medical Director
Author(s): Dr C Kelly Associate Medical Director

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B1
Corporate Risk Register: No risks on risk register

Purpose of this paper:
To provide the board with the mortality information on a monthly basis. It is also to highlight what analysis has taken place with the data and the actions which have been taken to mitigate the issue and the future focus.

Summary of Key Points:
The trust position on 12 month rolling HSMR has decreased to 107 as of June’s figures. This is an actual figure of 106.7 rounded up. It shows a slightly decreasing trend in the HSMR but the trust should remain vigilant as it is still in the upper quartile for this data.

The SHMI is 110. This remains the same figure as it is rebased quarterly.

Board action required:
For noting
1.0 Introduction

1.1 The data being reported is up to June 2017. The trust is currently has an HSMR of 107. This is the same figure as was reported for May. However the May figure in this month’s data has been updated to 109. This is due to the further coding of cases following the writing of the last report. The trust is hovering around this figure for the last few months. This is line with the CUSUM data.

1.2 The crude mortality in proportion to discharges has seen a significant decrease increase in June with their being 75 deaths in that month as opposed to 99 in May. This has seen the percentage drop to 1.24% with an overall 3 month total of 1.44%. This is consistently below 1.5% on a 3 monthly total.

1.3 Weekend crude mortality shows Saturday as having a higher rate than Sunday with an overall rate of 3.20%. This is an improvement from recent months down from 3.34 last month.

1.4 Mortality by day of the week remains higher at weekends but not statistically significant. This will be discussed during the Hospital and Quality alerts group meeting.

1.5 The quality improvement piece of work around the management of urinary tract infections is due to be presented at the next mortality meeting with discussion around action plans and improvement intervention.

1.6 The case notes of diagnosis of myocardial infarction are currently being reviewed. The findings and the action plan will be presented following analysis and theme building.

1.7 The CHKS portal allows the trust to review CUSUM scoring and trends of diagnosis which may cause issues in the future to be reviewed earlier than an official alert.

1.8 CHKS also have their own mortality indicator. This is risk adjusted mortality index (RAMI). There may be multiple factors influencing the figures some statistical as well as operational. An area where the mortality group intends to focus is on this index.

1.9 CHKS RAMI gives the trust a figure of 94 (not an outlier) and a SHMI of 110, in hospital deaths versus out of hospital deaths. If a review of the difference between the two caseloads were undertaken this may allude to improvements that can be made to improve the national HSMR picture. The trust will have to work closely with the community based services as a collaborative approach is necessary.

1.10 The trust mortality policy incorporating the recommendations from the learning from deaths review is published this month.
2.0 In summary

2.1 The HSMR is reported as 107 this month SHMI is 110. On-going work regarding the diagnosis codes which have alerted. Collaborative working with community to understand the difference within RAMI and SHMI

Dr Conrad Wareham
Medical Director
September 2017
SECTION A

1. HSMR - Jul 16 to Jun 17
2. SHMI - Jan to Dec 16
3. HSMR CUSUM Trust-Wide - Jul 16 to Jun 17
4. Crude Mortality in month and proportion of discharges - Apr to Jun 17

<table>
<thead>
<tr>
<th>Provider Spell</th>
<th>Expected</th>
<th>SHMI</th>
<th>HSMR 12 month rolling</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE ROTHERHAM NHS FOUNDATION TRUST</td>
<td>40,876</td>
<td>1,382.90</td>
<td>110.13</td>
</tr>
<tr>
<td>LEEDS TEACHING HOSPITALS NHS TRUST</td>
<td>133,672</td>
<td>4,292.52</td>
<td>97.87</td>
</tr>
<tr>
<td>SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>112,196</td>
<td>3,728.49</td>
<td>98.46</td>
</tr>
<tr>
<td>YORK TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>86,547</td>
<td>2,176.55</td>
<td>107.21</td>
</tr>
<tr>
<td>HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST</td>
<td>84,013</td>
<td>2,032.05</td>
<td>97.40</td>
</tr>
<tr>
<td>MID YORKSHIRE HOSPITALS NHS TRUST</td>
<td>98,143</td>
<td>2,971.17</td>
<td>98.86</td>
</tr>
<tr>
<td>DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST</td>
<td>77,413</td>
<td>2,270.35</td>
<td>103.63</td>
</tr>
<tr>
<td>CALDERDALE AND HUDDERFIELD NHS FOUNDATION TRUST</td>
<td>66,162</td>
<td>1,400.30</td>
<td>104.73</td>
</tr>
<tr>
<td>BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td>75,557</td>
<td>1,949.56</td>
<td>97.48</td>
</tr>
<tr>
<td>BARNSLEY HOSPITALS NHS FOUNDATION TRUST</td>
<td>42,125</td>
<td>1,308.59</td>
<td>99.15</td>
</tr>
<tr>
<td>AIREDALE NHS FOUNDATION TRUST</td>
<td>34,833</td>
<td>961.40</td>
<td>96.56</td>
</tr>
<tr>
<td>HARROGATE AND DISTRICT NHS FOUNDATION TRUST</td>
<td>26,225</td>
<td>776.34</td>
<td>93.98</td>
</tr>
</tbody>
</table>

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Overall summary

<table>
<thead>
<tr>
<th>3 months</th>
<th>Apr -17</th>
<th>May -17</th>
<th>Jun -17</th>
<th>3 months total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spells</td>
<td>5,402</td>
<td>5,323</td>
<td>5,390</td>
<td>16,222</td>
</tr>
<tr>
<td>Deaths</td>
<td>79</td>
<td>99</td>
<td>75</td>
<td>253</td>
</tr>
<tr>
<td>Crude Rate</td>
<td>1.45%</td>
<td>1.50%</td>
<td>1.36%</td>
<td>1.49%</td>
</tr>
</tbody>
</table>
### 5. HSMR - 10 Highest - Jul 16 - Jun 17

<table>
<thead>
<tr>
<th>CCS Group</th>
<th>Included Spells</th>
<th>Observed</th>
<th>Expected</th>
<th>Obs-Exp</th>
<th>Observed Rate</th>
<th>Expected Rate</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Change</th>
<th>Peer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 - Cancer of ovary</td>
<td>17</td>
<td>2</td>
<td>0.55</td>
<td>1.45</td>
<td>11.77%</td>
<td>3.22%</td>
<td>365.3</td>
<td>49.2</td>
<td>642.5%</td>
<td>94.4</td>
</tr>
<tr>
<td>190 - Chronic ulcer of skin</td>
<td>62</td>
<td>8</td>
<td>2.61</td>
<td>5.4</td>
<td>12.90%</td>
<td>4.21%</td>
<td>306.5</td>
<td>118.6</td>
<td>158.4%</td>
<td>95.6</td>
</tr>
<tr>
<td>24 - Cancer of breast</td>
<td>252</td>
<td>3</td>
<td>1.4</td>
<td>1.6</td>
<td>1.19%</td>
<td>0.56%</td>
<td>213.7</td>
<td>125.5</td>
<td>70.3%</td>
<td>98.9</td>
</tr>
<tr>
<td>155 - Other gastrointestinal disorders</td>
<td>1103</td>
<td>13</td>
<td>7.2</td>
<td>5.8</td>
<td>1.18%</td>
<td>0.65%</td>
<td>181.8</td>
<td>58.1</td>
<td>213.1%</td>
<td>96.1</td>
</tr>
<tr>
<td>145 - Intestinal obstruction without hernia</td>
<td>130</td>
<td>16</td>
<td>9</td>
<td>7</td>
<td>12.31%</td>
<td>6.94%</td>
<td>177.4</td>
<td>138.0</td>
<td>28.5%</td>
<td>90.7</td>
</tr>
<tr>
<td>68 - Senility and organic mental disorders</td>
<td>82</td>
<td>9</td>
<td>5.2</td>
<td>5.4</td>
<td>10.98%</td>
<td>4.21%</td>
<td>173.6</td>
<td>44.2</td>
<td>292.7%</td>
<td>100.7</td>
</tr>
<tr>
<td>158 - Chronic renal failure</td>
<td>7</td>
<td>2</td>
<td>1.2</td>
<td>0.8</td>
<td>28.57%</td>
<td>6.94%</td>
<td>166.9</td>
<td>110.6</td>
<td>50.9%</td>
<td>93.0</td>
</tr>
<tr>
<td>224 - Other perinatal conditions</td>
<td>366</td>
<td>13</td>
<td>7.8</td>
<td>5.2</td>
<td>3.55%</td>
<td>2.14%</td>
<td>165.6</td>
<td>113.7</td>
<td>45.7%</td>
<td>91.3</td>
</tr>
<tr>
<td>17 - Cancer of pancreas</td>
<td>27</td>
<td>8</td>
<td>5.3</td>
<td>2.73</td>
<td>29.63%</td>
<td>15.71%</td>
<td>151.9</td>
<td>47.6</td>
<td>219.0%</td>
<td>94.7</td>
</tr>
</tbody>
</table>

* Statistically significant outlier in the upper quartile of the national peer

### 6. HSMR - 10 Lowest - Jul 16 - Jun 17

<table>
<thead>
<tr>
<th>CCS Group</th>
<th>Included Spells</th>
<th>Observed</th>
<th>Expected</th>
<th>Obs-Exp</th>
<th>Observed Rate</th>
<th>Expected Rate</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Change</th>
<th>Peer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>233 - Intracranial injury</td>
<td>101</td>
<td>8</td>
<td>16.6</td>
<td>-8.6</td>
<td>7.92%</td>
<td>16.42%</td>
<td>48.2</td>
<td>63.1</td>
<td>-23.6%</td>
<td>91.8</td>
</tr>
<tr>
<td>12 - Cancer of esophagus</td>
<td>55</td>
<td>2</td>
<td>4.1</td>
<td>-2.14</td>
<td>3.64%</td>
<td>7.54%</td>
<td>48.3</td>
<td>110.4</td>
<td>-56.3%</td>
<td>94.1</td>
</tr>
<tr>
<td>29 - Cancer of prostate</td>
<td>113</td>
<td>1</td>
<td>2.05</td>
<td>-1.05</td>
<td>0.89%</td>
<td>1.82%</td>
<td>48.7</td>
<td>16.4</td>
<td>170.2%</td>
<td>93.6</td>
</tr>
<tr>
<td>237 - Complication of device; implant or graft</td>
<td>961</td>
<td>3</td>
<td>5.6</td>
<td>-2.6</td>
<td>0.31%</td>
<td>0.58%</td>
<td>53.6</td>
<td>30.4</td>
<td>76.2%</td>
<td>81.0</td>
</tr>
<tr>
<td>231 - Other fractures</td>
<td>192</td>
<td>3</td>
<td>5.2</td>
<td>-2.2</td>
<td>1.56%</td>
<td>2.71%</td>
<td>57.7</td>
<td>97.2</td>
<td>-40.6%</td>
<td>93.1</td>
</tr>
<tr>
<td>43 - Malignant neoplasm without specification of site</td>
<td>16</td>
<td>1</td>
<td>1.6</td>
<td>-0.6</td>
<td>6.25%</td>
<td>10.02%</td>
<td>62.4</td>
<td>74.6</td>
<td>-16.1%</td>
<td>90.9</td>
</tr>
<tr>
<td>38 - Non-Hodgkin’s lymphoma</td>
<td>474</td>
<td>4</td>
<td>6</td>
<td>-2</td>
<td>0.84%</td>
<td>1.27%</td>
<td>66.7</td>
<td>85.7</td>
<td>-22.1%</td>
<td>97.0</td>
</tr>
<tr>
<td>157 - Acute and unspecified renal failure</td>
<td>242</td>
<td>22</td>
<td>32</td>
<td>-10.1</td>
<td>9.09%</td>
<td>13.28%</td>
<td>68.4</td>
<td>67.4</td>
<td>1.5%</td>
<td>90.8</td>
</tr>
<tr>
<td>117 - Other circulatory disease</td>
<td>203</td>
<td>2</td>
<td>2.86</td>
<td>-0.86</td>
<td>0.99%</td>
<td>1.41%</td>
<td>70.0</td>
<td>180.8</td>
<td>-61.3%</td>
<td>100.7</td>
</tr>
<tr>
<td>19 - Cancer of bronchus; lung</td>
<td>146</td>
<td>10</td>
<td>14</td>
<td>-4</td>
<td>6.85%</td>
<td>9.58%</td>
<td>71.5</td>
<td>86.4</td>
<td>-17.3%</td>
<td>96.5</td>
</tr>
</tbody>
</table>

### 7. SHMI - 12 Highest - Jan to Dec 16

<table>
<thead>
<tr>
<th>SHMI Category</th>
<th>Condition</th>
<th>Cases</th>
<th>Observed</th>
<th>Expected</th>
<th>SHMI</th>
<th>Excess Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Schizophrenia &amp; related disorders and other mental conditions</td>
<td>20</td>
<td>1</td>
<td>0.2</td>
<td>482.2</td>
<td>0.8</td>
</tr>
<tr>
<td>80</td>
<td>Lung disease due to external agents</td>
<td>4</td>
<td>2</td>
<td>0.6</td>
<td>361.5</td>
<td>1.4</td>
</tr>
<tr>
<td>17</td>
<td>Melanomas and Other non-epithelial cancer of skin</td>
<td>32</td>
<td>2</td>
<td>0.6</td>
<td>345.5</td>
<td>1.4</td>
</tr>
<tr>
<td>5</td>
<td>Other &amp; ill-defined heart disease</td>
<td>5</td>
<td>1</td>
<td>0.3</td>
<td>330.4</td>
<td>0.7</td>
</tr>
<tr>
<td>49</td>
<td>Paralysis Late effects of cerebrovascular disease</td>
<td>23</td>
<td>2</td>
<td>0.7</td>
<td>292.0</td>
<td>1.3</td>
</tr>
<tr>
<td>105</td>
<td>Inflammatory diseases of female pelvis</td>
<td>536</td>
<td>4</td>
<td>1.4</td>
<td>283.2</td>
<td>2.6</td>
</tr>
<tr>
<td>68</td>
<td>Peripheral and visceral atherosclerosis</td>
<td>34</td>
<td>17</td>
<td>6.4</td>
<td>267.1</td>
<td>10.6</td>
</tr>
<tr>
<td>62</td>
<td>Conduction disorders</td>
<td>4</td>
<td>1</td>
<td>0.7</td>
<td>239.4</td>
<td>2.3</td>
</tr>
<tr>
<td>139</td>
<td>Malaise &amp; fatigue</td>
<td>30</td>
<td>2</td>
<td>1.0</td>
<td>209.9</td>
<td>1.0</td>
</tr>
<tr>
<td>24</td>
<td>Cancer of kidney renal pelvis and other urinary organs</td>
<td>33</td>
<td>4</td>
<td>1.9</td>
<td>206.6</td>
<td>2.1</td>
</tr>
<tr>
<td>89</td>
<td>Intestinal obstruction without hernia</td>
<td>150</td>
<td>27</td>
<td>13.3</td>
<td>203.5</td>
<td>13.7</td>
</tr>
<tr>
<td>69</td>
<td>Aortic peripheral and visceral artery aneurysms</td>
<td>11</td>
<td>4</td>
<td>2.1</td>
<td>192.2</td>
<td>1.9</td>
</tr>
</tbody>
</table>

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### 8 & 9. HSMR - Worst and Best Trusts - Jul 16 to Jun 17

#### 10. SHMI - Worst Performing Trusts - Jan to Dec 16

<table>
<thead>
<tr>
<th>Acute Trust</th>
<th>Spells</th>
<th>Expected</th>
<th>SHMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust 1</td>
<td>28,244</td>
<td>1051.81</td>
<td>118.94</td>
</tr>
<tr>
<td>Acute Trust 2</td>
<td>40,338</td>
<td>1539.63</td>
<td>117.56</td>
</tr>
<tr>
<td>Acute Trust 3</td>
<td>54,198</td>
<td>2029.24</td>
<td>117.43</td>
</tr>
<tr>
<td>Acute Trust 4</td>
<td>32,712</td>
<td>1166.68</td>
<td>115.88</td>
</tr>
<tr>
<td>Acute Trust 5</td>
<td>31,505</td>
<td>1030.14</td>
<td>115.51</td>
</tr>
<tr>
<td>Acute Trust 6</td>
<td>31,206</td>
<td>1401.43</td>
<td>115.17</td>
</tr>
<tr>
<td>Acute Trust 7</td>
<td>57,161</td>
<td>2090.15</td>
<td>114.25</td>
</tr>
<tr>
<td>Acute Trust 8</td>
<td>24,612</td>
<td>1032.14</td>
<td>114.13</td>
</tr>
<tr>
<td>Acute Trust 9</td>
<td>87,051</td>
<td>2796.35</td>
<td>114.01</td>
</tr>
<tr>
<td>Acute Trust 10</td>
<td>56,134</td>
<td>2215.15</td>
<td>112.18</td>
</tr>
</tbody>
</table>

Note: NHS Digital publish SHMI every quarter (usually at the end of Jan, Apr, Jul, Oct)
### SECTION D (weekends)

11. a and b Weekend Mortality - All Diagnoses - Jul 16 to Jun 17

12. HSMR Basket of 56 diagnosis groups - mortality by day of admission - Jul 16 to Jun 17

<table>
<thead>
<tr>
<th>11. a and b Weekend Mortality - All Diagnoses - Jul 16 to Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>Admissions</td>
</tr>
<tr>
<td>Deaths*</td>
</tr>
<tr>
<td>Crude rate</td>
</tr>
</tbody>
</table>

*Deaths may have occurred on any day of the week

<table>
<thead>
<tr>
<th>12. HSMR Basket of 56 diagnosis groups - mortality by day of admission - Jul 16 to Jun 17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day of Admission</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>HSMR</td>
</tr>
<tr>
<td>1 - Monday</td>
</tr>
<tr>
<td>2 - Tuesday</td>
</tr>
<tr>
<td>3 - Wednesday</td>
</tr>
<tr>
<td>4 - Thursday</td>
</tr>
<tr>
<td>5 - Friday</td>
</tr>
<tr>
<td>6 - Saturday</td>
</tr>
<tr>
<td>7 - Sunday</td>
</tr>
</tbody>
</table>
**SECTION E (extremes of stay)**

13a, 14a, 15a - In-hospital SHMI* by Length of Stay - Jul 16 to Jun 17

13b, 14b, 15b - Crude Mortality by Length of Stay - Jul 16 to Jun 17

---

### 13a, 14a, 15a - In-hospital SHMI* by Length of Stay - Jul 16 to Jun 17

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Included Spells</th>
<th>Observed</th>
<th>Expected</th>
<th>Obs-Exp</th>
<th>Observed Rate</th>
<th>Expected Rate</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Change</th>
<th>Peer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Days</td>
<td>11,052</td>
<td>81</td>
<td>95</td>
<td>-14.5</td>
<td>0.73%</td>
<td>0.86%</td>
<td>84.8</td>
<td>79.2</td>
<td>7.1%</td>
<td>37.2</td>
</tr>
<tr>
<td>1 Day</td>
<td>10,562</td>
<td>141</td>
<td>166</td>
<td>-25</td>
<td>1.34%</td>
<td>1.57%</td>
<td>84.9</td>
<td>68.8</td>
<td>23.5%</td>
<td>63.2</td>
</tr>
<tr>
<td>2 Days</td>
<td>5,250</td>
<td>94</td>
<td>127</td>
<td>-33</td>
<td>1.79%</td>
<td>2.43%</td>
<td>73.8</td>
<td>71.8</td>
<td>2.9%</td>
<td>61.8</td>
</tr>
<tr>
<td>21+ Days</td>
<td>1,071</td>
<td>117</td>
<td>114</td>
<td>3.2</td>
<td>10.92%</td>
<td>10.62%</td>
<td>102.8</td>
<td>101.3</td>
<td>1.5%</td>
<td>98.7</td>
</tr>
</tbody>
</table>

*In-hospital SHMI excludes out of hospital deaths which account for approximately 30% of the SHMI figure. As a result, the in-hospital SHMI is based to approximately 70, rather than 100.*

---

### 13b, 14b, 15b - Crude Mortality by Length of Stay - Jul 16 to Jun 17

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Spells</th>
<th>Deaths</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Change</th>
<th>Peer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Days</td>
<td>42,274</td>
<td>81</td>
<td>0.19%</td>
<td>0.15%</td>
<td>26.2%</td>
<td>0.12%</td>
</tr>
<tr>
<td>1 Day</td>
<td>9,792</td>
<td>141</td>
<td>1.44%</td>
<td>1.21%</td>
<td>19.1%</td>
<td>1.06%</td>
</tr>
<tr>
<td>2 Days</td>
<td>5,066</td>
<td>94</td>
<td>1.86%</td>
<td>1.88%</td>
<td>-1.1%</td>
<td>1.60%</td>
</tr>
<tr>
<td>21 Days+</td>
<td>1,071</td>
<td>117</td>
<td>10.92%</td>
<td>11.29%</td>
<td>-3.3%</td>
<td>11.30%</td>
</tr>
</tbody>
</table>
### SECTION F
16. Patient Safety Indicators - Jul 16 to Jun 17

<table>
<thead>
<tr>
<th>Description</th>
<th>Site Numerator</th>
<th>Current Period</th>
<th>Previous Period</th>
<th>Change</th>
<th>25th Percentile</th>
<th>Peer Value</th>
<th>75th Percentile</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths in Low Mortality CCS Groups</td>
<td>15</td>
<td>0.10205%</td>
<td>0.06217%</td>
<td>+0.0393%</td>
<td>0.08055%</td>
<td>0.11813%</td>
<td>0.14655%</td>
<td>Green</td>
</tr>
<tr>
<td>Dekkutus ulcer</td>
<td>180</td>
<td>2.20859%</td>
<td>2.33724%</td>
<td>-0.1286%</td>
<td>3.06774%</td>
<td>4.4572%</td>
<td>5.6772%</td>
<td>Green</td>
</tr>
<tr>
<td>Accidental puncture or laceration</td>
<td>26</td>
<td>0.14238%</td>
<td>0.11429%</td>
<td>+0.0283%</td>
<td>0.14733%</td>
<td>0.26036%</td>
<td>0.32036%</td>
<td>Green</td>
</tr>
<tr>
<td>Rate of Deaths in hospital within 30 days of elective surgery</td>
<td>6</td>
<td>0.08124%</td>
<td>0.02738%</td>
<td>+0.0538%</td>
<td>0.01502%</td>
<td>0.08048%</td>
<td>0.0970%</td>
<td>Green</td>
</tr>
<tr>
<td>Rate of Deaths in hospital within 30 days of Non elective surgery</td>
<td>93</td>
<td>2.20859%</td>
<td>2.15324%</td>
<td>+0.0555%</td>
<td>1.12139%</td>
<td>1.43724%</td>
<td>1.74054%</td>
<td>Green</td>
</tr>
<tr>
<td>Perinatal in-hospital hip fracture (fall)</td>
<td>1</td>
<td>0.0015881%</td>
<td>0.00149%</td>
<td>+0.00009%</td>
<td>0.00015009%</td>
<td>0.0003501%</td>
<td>0.0007866%</td>
<td>Green</td>
</tr>
<tr>
<td>Postpartum hemorrhage</td>
<td>468</td>
<td>18.050%</td>
<td>11.124%</td>
<td>+6.9256%</td>
<td>12.331%</td>
<td>19.381%</td>
<td>25.560%</td>
<td>Green</td>
</tr>
<tr>
<td>Postoperative acute respiratory failure</td>
<td>1</td>
<td>0.003538%</td>
<td>0.002627%</td>
<td>+0.00090%</td>
<td>0.002623%</td>
<td>0.05351%</td>
<td>0.05300%</td>
<td>Green</td>
</tr>
<tr>
<td>Post operative pulmonary embolism or deep vein thrombosis</td>
<td>2</td>
<td>0.006071%</td>
<td>0.007052%</td>
<td>-0.0980%</td>
<td>0.0073501%</td>
<td>0.00822%</td>
<td>0.000089%</td>
<td>Green</td>
</tr>
<tr>
<td>Post operative sepsis</td>
<td>-</td>
<td>0.00149%</td>
<td>0.00149%</td>
<td>+0.000000%</td>
<td>0.0015881%</td>
<td>0.001895%</td>
<td>0.0022%</td>
<td>Green</td>
</tr>
<tr>
<td>Postoperative wound infection</td>
<td>56</td>
<td>1.271%</td>
<td>1.50754%</td>
<td>-0.2364%</td>
<td>0.874%</td>
<td>1.176%</td>
<td>1.815%</td>
<td>Green</td>
</tr>
<tr>
<td>% Obstetric trauma (3rd or 4th degree lacerations) vaginal delivery with instrument</td>
<td>18</td>
<td>0.3104%</td>
<td>0.2041%</td>
<td>+0.1063%</td>
<td>0.077%</td>
<td>0.095%</td>
<td>0.178%</td>
<td>Green</td>
</tr>
<tr>
<td>% Obstetric trauma (3rd or 4th degree lacerations) vaginal delivery without instrument</td>
<td>29</td>
<td>1.8560%</td>
<td>2.07326%</td>
<td>-0.2172%</td>
<td>1.2213%</td>
<td>2.53854%</td>
<td>2.88515%</td>
<td>Green</td>
</tr>
<tr>
<td>Other obstetric trauma</td>
<td>28</td>
<td>0.0267%</td>
<td>0.7454%</td>
<td>-0.7187%</td>
<td>0.5260%</td>
<td>1.2205%</td>
<td>1.2422%</td>
<td>Green</td>
</tr>
</tbody>
</table>
Report: Data Quality Report

Presented by: Chris Holt, Director of Strategy and Transformation
Author(s): James Rawlinson, Director of Health Informatics
Monica Jones, Associate Director of Information Services

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
NHS Digital: IGTK Information Governance Standard 500
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B8
Corporate Risk Register: None

Purpose of this paper:
To present to the TRFT Board Meeting details of activity related to progress with developments in data quality.

Summary of Key Points:
The key points arising from the report are:

• The Data Quality Assurance (DQA) process is now embedded in to Business as Usual practices at TRFT and has involved full data quality review of all Trust Board performance (including constitutional KPIs) indicators. All indicators in the “new” IPR have been updated and revised.
• The Quality Audit reinforced the approach to achieving a level 6 requires external review and audit. These are now part of the internal audit process.
• An internal independent review of the DQA has taken place. There are a number of recommendations from this review (see report).
• Concerns have been raised regarding quality of data in relation to accurate in Month forecasting and activity recording. Action plans and governance structures are being put in place to provide oversight and control.
• Recommendations relating to DQA process as a result of the above audit have been implemented.

Board action required: For noting
1.0 Introduction

1.1 This paper provides an update on the data quality assurance processes undertaken to provide assurance that the indicators reported monthly to the TRFT Board of Directors follow national guidance and are reported and monitored accordingly.

1.2 The paper also provides an update of increasing concern regarding data quality of activity relating to financial forecasting and overview of immediate and longer term actions that are taking place.

2.0 DQ Progress

2.1 From the last update to the board where we covered the data quality assurance process for the Integrated Performance Report (IPR) we highlighted via the Action Plans the areas that required attention – the prime areas for attention continue to be:

- Contemporaneous – Is the data recorded real time or within 24 hours?
- Completeness – Have all the required elements been completed?
- Sign off – Is there a named responsible individual who will authorise the data as accurate and true?
- Auditable process – Is it a process that can be audited and has it been audited?

2.2 All indicators have been further reviewed by the Health Informatics leadership team and at the time of writing are pending updates (delays due to annual leave and summer) before being distributed to executive leads prior to board submission.

2.3 The actions plans for all those indicators were produced and priority has now been given to the 30 indicators on the new IPR and detailed action plans with updated statements for each indicator are loaded onto the corporate Data Quality Assurance - Top 30 IPR intranet site.

2.4 The recent annual, external PWC audit of the Quality Report, assessed three mandated healthcare indicators (4 Hour, 18 week Referral to Treatment (‘RTT’), Delays to Transfer of Care (‘DTOC’) recommended a number of areas for further improvement. These are now being picked up as part of the internal audit by TIAA.

3.0 DQ Assurance Timeline - Update

3.1 The actions included those listed in the table below:

<table>
<thead>
<tr>
<th>Expected timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Informatics to update and review 30 IPR assurance statements</td>
<td>30 June 2016</td>
</tr>
<tr>
<td>All Data owners and Head of Governance to review assurance statements</td>
<td>31 July 2017</td>
</tr>
<tr>
<td>Updated or amended statements and improvement plans to be signed by executive owners</td>
<td>29 September 2017</td>
</tr>
</tbody>
</table>
Recommendations from Head of Governance review of DQA:

**Recommendation 1a:** an average score should not be used; instead the total score of the indicator should be shown e.g. 24/36 in conjunction with the data assurance kite mark hexagon detailing the RAG rating by criteria.

**Recommendation 1b:** a key describing the scoring system used should be added to the Assessment spread sheet to make it clear the score awarded for a response of ‘Inadequate’, ‘Adequate’ and ‘Robust’.

**Recommendation 2:** The IPR should return to using the data assurance kite mark hexagon to provide an accurate picture of the level of assurance available for every data indicator used on the IPR.

**Recommendation 3:** A role description is created for the Executive Director / Senior Manager in relation to signing off the data quality assurance rating for each data item in the IPR. This description should include the assurance the Executive Director / Senior Manager needs to be in possession of before they sign off the data indicator. This role description should be approved by the Board of Directors before it is used.

**Recommendation 4:** A review of the model of validators being managed by the clinical Divisions rather than the Information Services department should be undertaken to establish whether the Trust’s validation model is as robust and justifiable as it should be. This review should take into account best practice from other organisations.

### 4.0 Emerging Data quality concerns

4.1 Divisional finance managers have raised concerns over the last 2 months at a number of forums regarding accuracy of financial activity data relating to their areas.

4.2 Health Informatics did have technical issues with the piece of software that codes outpatients procedures and this was rectified in time for freeze submission, but did cause issues with financial forecasting at flex for M3 & M4 – these have been rectified.

4.3 As a result of concerns raised, Health Informatics have worked with divisions in deep diving some of these issues and also providing educational updates as to how in month forecasting on an un-coded position can be subject to expected to variations.

4.4 Director of Finance is leading a task and finish group across the organisation to address these concerns group around the following themes:
   - Activity and confirm we are capturing the work we do
   - Coding and Pricing and are we getting the correct tariffs
   - System change processes and is there an agree change control process in place are financial systems
   - Timeliness of coding and how we can progress coding to within 5-10 days of month end
5.0 Data Quality Summary

5.1 The Trust has committed to fully implementing the quality assurance process for the Integrated Performance Report (IPR). This provides the Trust with a robust process for quality assuring all indicators report on the IPR. The data quality icon for each of the indicators assessed is now visible on the report and a DQ flag is shown as well.

5.2 An ongoing process of review by data owners, Head of Governance and internal / audit has happened and as per the action plans the issues identified are being identified, addressed and will be resolved with executive leadership to ensure completion.

5.3 There is some level of concern around accuracy of our financial data quality and DoF leading as task and finish group, with assurance given to FPC re: progress and action plans.

James Rawlinson
Director of Health Informatics
September 2017
BOARD MEETING: 26 September 2017

Agenda item: 347/17

Report: Governance Report

Presented by: Lisa Reid, Head of Governance
Author(s): Anna Milanec, Director of Corporate Affairs/ Company Secretary

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance
Finance: Strong, financial foundations
Partners: Securing the future together

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B6 and B8
Corporate Risk Register: 3520, 3908, 5084

Purpose of this paper:
This paper intends to provide the Board with details of progress against various governance issues, and provides a horizon scan of governance based matters that are pertinent to the Board / the Trust.

Summary of Key Points:

- Third party information governance breach reported to the ICO with local and regulatory investigations ongoing;
- Areas for annual IG Toolkit audit have been advised;
- National winter flu campaign has now commenced;
- NHSI launch improvement tool to assist with patient flow;
- Details published regarding the Health Service Safety Investigations Bill which provides powers for a new body to investigate serious safety incidents;
- Publications issued relating to quality improvement and the role of boards, and supplemental guidance on well led reviews.

Board action required:
For noting.
1.0 Introduction

1.1 This report provides an update on board governance, and regulatory matters affecting board governance, for the period from the last report to mid-September 2017.

2.0 Information Governance / IG Toolkit

2.1 The Trust has had to submit a report to the ICO advising that an information governance breach, involving the data of 1200 patients, has occurred. The breach was not caused by the Trust, but rather, through a third party contracted by the Trust to handle such data.

2.2 An investigation has been undertaken and the contract with the third party temporarily suspended until details are clearer.

2.3 In the meantime, the ICO is conducting its own investigation with which the Trust is co-operating.

2.4 In the temporary absence of the SIRO, the Caldicott Guardian and IG Assurance and Security Manager are monitoring the situation.

2.5 The Trust’s internal auditors have been in touch to advise which areas of the IG Toolkit they will be looking at in detail for the 2017/18 audit. Standards being audited include those relating to IG training (112), systems security (308, 311, 313, 402), clinical coding systems (505) and Data Protection Assurance - patient consent prior to use (202).

2.6 Beginning at the Information Governance Committee meeting in October 2017, Standard Owners will be asked to attend to provide assurance that they have uploaded appropriate evidence to the Toolkit to support compliance with the standards.

2.7 With regard to IG training, the new on-line training takes – on average – 75 – 90 minutes to complete so my team are also providing spot training for those working in ‘hard to reach’ areas, such as those working in the UECC. By setting up in the UECC itself, colleagues can attend the training room at some point during the day, to suit them and to suit the demand for services.

2.8 The monthly IG MAST compliance list also provides us with data which highlights areas (other than UECC) where compliance may be low, or particular staff groups which appear to be behind with their training. Again, these areas have been identified and my team are arranging to target areas and staff groups.

2.9 Non-compliance with IG training is across the Trust, and ranges from lower bandings through to those in senior leadership positions.

2.10 It also appears that not all new starters within the Trust have completed their IG training – contrary to the requirements of the Information Governance Toolkit – despite assurances received. This matter is being looked into, and a risk has been added to the risk register in the meantime.
3.0 Regulatory and legislative matters

3.1 The **winter flu campaign** has commenced with a letter to Medical Directors and Directors of Nursing on 13 September advising that uptake of the vaccination to healthcare workers in England last year was 63.2%, which was a 12.6% increase on the previous year.

3.2 Trusts are also reminded that in order to benefit from the two year (2017/18 and 2018/19) CQUIN attached to the initiative, Trusts must achieve a vaccination uptake rate indicator of 70% of **frontline staff** in year one, rising to 75% in year two.

3.3 Trialled with 30 acute hospitals, NHSI have launched a tool to help with the improvement of **patient flow**. The tool, available through the Model Hospital portal, links to initiatives already used, such as the SAFER patient flow bundle and **Red2Green** bed days, but uses a wide variety of data to help support the identity of ‘blockages’ in the system.

3.4 Last week, the DoH published more details about the draft **Health Service Safety Investigations Bill** which enshrines in law a mandate given to the Health Service Safety Investigations Body (HSSIB) by DH to investigate patient safety incidents. The body will be independent from the NHS and at arms-length from the government and is aimed to give the public confidence in the independence of the body and that it will conduct fair and unbiased investigations which provide system-wide learning from the circa 24,000 serious incidents every year.

3.5 The Bill proposes three undertakings to:
   (i) establish a new independent investigation body (HSSIB)) aimed at improving patient safety;
   (ii) create a ‘safe space’ by prohibiting the disclosure of certain information held by the HSSIB in connection with an investigation; and
   (iii) make provision for the HSSIB to accredit NHS trusts and foundation trusts to carry out investigations into patient safety with the benefit of ‘safe space’.

3.6 It is also envisaged that the new legislation will improve investigative capability in the NHS and will remove inefficient and ineffective practice to help embed a culture of learning and safety improvement.

3.7 Although there is some overlap in their remits, one of the key differences between the HSSIB and CQC appears to be their responsibility to disclose findings and reports. Whilst the CQC will continue to be obliged to publically disclose findings and reports, the HSSIB will not. The reasoning given for this is ostensibly to nurture a culture of openness.

4. Publications

4.1 NHSI have published their guide, “**Building capacity and capability** for improvement: embedding quality improvement skills in NHS providers” which outlines the Institute for Healthcare Improvement (IHI) approach of ‘dosing’ to embed quality improvement skills.

4.2 It is claimed that the approach can support NHS bodies to become learning organisations (Berwick 2913) and promotes a shared empowering leadership approach highlighted in recent reports (The Kings Fund, 2014, 2017).
4.3 The BMJ has published an extract of a study of ‘How do hospital boards govern for quality improvement? [QI]. A mixed methods study of 15 organisations in England.’¹

4.4 Some of the measures of organisational maturity used in relation to governing for QI, included:
- where QI came on a board agenda (high maturity = top of the agenda);
- whether time was spent on QI elsewhere other than board (high maturity = QI is dealt with predominately at the board committee with escalation being brought to the board meeting);
- does the Trust use QI-specific data (high maturity = data available and presented to board members);
- is data linked to other data (e.g. staffing, sickness absence) (high maturity = data clearly linked and discussions about QI take into account all the data available);
- Does the board benchmark and compare with other organisations (high maturity = comparative assessment with other organisations);
- To what extent are patients and the public involved and prioritised in QI (high maturity = fully involved, priorities identified and discussed with patients / public).

4.5 The study concluded that boards with higher levels of maturity in relation to governing for QI had the following characteristics: explicitly prioritising QI; balancing short-term (external) priorities with long-term (internal) investment in QI; using data for QI, not just quality assurance; engaging staff and patients in QI; and encouraging a culture of continuous improvement.

4.6 Also published this month is NHSI supplemental guidance to Well Led Reviews, ‘Getting the most from developmental well-led reviews: commissioning external supplies and working with peer reviewers’.

4.7 The guidance helps providers get the most of reviews using the well led framework, and particularly provides advice on an appropriate specification for the essential features of a review.

Anna Milanec,
Director of Corporate Affairs/Company Secretary
September 2017

¹ Jones L, Pomeroy L, Robert G, et al
How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England
BMJ Qual Saf Published Online First: 08 July 2017. doi: 10.1136/bmjqs-2016-006433
BOARD MEETING: 26 September 2017

Report: Revised Business Case Process

Presented by: Simon Sheppard, Director of Finance
Author(s): Mark Bloy, Deputy Director of Finance

Strategic Objective:
- Colleagues: Engaged, accountable colleagues
- Governance: Trusted, open governance
- Finance: Strong, financial foundations

Regulatory relevance:
- NHSI: Licence Condition FT4
- CQC Domain: Effective/responsive/well-led

Risk Reference:
- BAF: B6, B9, B10
- Corporate Risk Register: No Risks on the Register

Purpose of this paper:
To present to the Board of Directors the outcome of a review undertaken regarding the documentation to be used and the process to be followed for approving business cases.

Summary of Key Points:
The key points arising from the report are:

- Future business cases will be produced in accordance with Treasury guidance, which provides a practical “step by step” guide to the development of business cases, using the Five Case Model.

- A localised business case template has been developed and will be used by the Trust for all of its internal business cases. All business cases to be produced for an external audience will follow the Five Case Model in terms of process and documentation.

- The process for approving business cases is defined in Standing Financial Instructions and remains unchanged following a recent review of the latter, which was approved at last month’s Board meeting.

- This report has been updated following feedback in August to include the impact upon patient outcomes and quality metrics, as appropriate.

Board action required: For approval
1. **Introduction**

1.1 Following the prolonged time frame for approving, what should have been a relatively straight-forward business case, for the replacement catheterisation laboratory equipment, it was agreed by the Director of Finance to review the documentation to be used and the process to be followed for approving future business cases.

1.2 This report highlights the outcome of that internal review, which will also need to be discussed and formally agreed with Business Investment Committee and Trust Management Committee.

2. **Documentation**

2.1 The previous business case template used by the Trust was something that was developed internally and was subject to criticism around the following points:

(a) Requirements could be somewhat lengthy sometimes;
(b) There could be scope for repetition/duplication within the various sections;
(c) Some sections were not always relevant;
(d) There was no standard template for the consistent presentation of financial information.
(e) The format was inconsistent with external requirements for producing business cases e.g. for Sustainability and Transformation Plans, Department of Health, etc.

2.2 Therefore, it has been decided to produce future business cases in accordance with Treasury guidance, which provides a practical “step by step” guide to the development of business cases, using the Five Case Model – using an approach which is both scalable and proportionate. It is recognised as best practice and is the Treasury’s standard methodology.

2.3 As quoted on the national web site:

“Experience has demonstrated that when this guidance is embedded in public sector organisations, better more effective and efficient spending decisions and implementation plans are produced. At the same time the approach when correctly understood and applied provides a more efficient planning and approval process saving between 30% and 40% in time taken and cost of production of business cases compared with unstructured approaches.”

2.4 The Five Case Model comprises the following key components:

(a) The Strategic Case;
(b) The Economic Case;
(c) The Commercial Case;
(d) The Financial Case; and
(e) The Management Case.

2.5 The Five Case Model overview of the business case development process uses the following templates:
2.6 The full Five Case Model will be used to produce substantial value business cases either internally or for those seeking to secure external funding, whereas per the guidance, the Business Justification template can be used in support of small and medium size investments (as judged nationally) i.e. typically those below £2 million whole life costs that are not novel or contentious in nature.

2.7 A localised Business Justification template has been developed and will be used by the Trust for all of its internal business cases. A copy of the template is attached in Appendix 1.

2.8 This localised business case template will be supplemented by a financial spreadsheet model that will ensure consistency and completeness when presenting financial information.

2.9 All business cases to be produced for an external audience will follow the Five Case Model in terms of process and documentation.

2.10 All business cases will require prospective sign-off by:

(a) Director of Clinical Services/Executive Director;
(b) Divisional General Manager/Corporate Head of Service;
(c) Divisional Head of Nursing (as appropriate);
(d) Responsible Finance Manager;
(e) Service Lead where the business case impacts on other services.

This will ensure that all aspects of the business case in terms of business needs, benefits and risks, as part of the case for change have been identified, considered and formally agreed by all affected/interested stakeholders.

3. Process

3.1 The process for approving business cases was not deemed to require further changes to that currently outlined in the Trust’s Standing Financial Instructions (SFIs).

3.2 A recent review of SFIs made no recommended changes to the approval process following discussions at Trust Management Committee and Audit Committee before being ratified by the Board.

3.3 A detailed communication on the business case approval process was circulated at the start of the current calendar year, a slightly revised version of which is attached at Appendix 2. This will be further revised as necessary and issued to support the launch of the new business case template in due course.
4. Guidance and Training

4.1 The national Five Case Model is supported by further useful documentation covering:

(a) A checklist for assessing business cases;
(b) A short “plain English” guide to assessing business cases;
(c) Clarification of business case guidance to support agile digital and information technology projects.

4.2 Access to private provider training and accreditation in best practice business cases is also available via the government web page.

4.3 The Healthcare Financial Management Association (HFMA) also provides an Online Academy – a hub for finance training (developed for non-finance professionals); for which the Trust is a member. The Director of Finance is planning to roll out this training as mandatory requirements as part of a structured development programme for all budget holders in the near future. The Academy includes a module which provides an overview of business cases, their importance and how they are applied, based upon the Five Case Model.

4.4 Furthermore, the Trust is a member of the Finance Skills Development Network, which is co-ordinated throughout Yorkshire & the Humber as part of a regional approach to the delivery of finance training to both finance and non-finance professionals throughout the NHS. Training in the preparation of business cases is a recurring requirement provided via the Network.

5. References

5.1 All the documents and additional links for the Five Case Model can be found on the government web page below:


5.2 Access to the HFMA website and relevant information is provided below.


Mark R. Bloy
Deputy Director of Finance
September 2017
Appendix 1

Business Case Template

Title:
Author:
Sponsor:
Version:
Date: 00/00/0000

Type of Business Case (Tick a box below):

REVENUE ☐ CAPITAL ☐
For more information on the content or status of this document please contact:

<table>
<thead>
<tr>
<th>Author:</th>
</tr>
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<tbody>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>E-mail:</td>
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</table>
1. Purpose

State clearly what the business justification is in support of. Typically – ‘this is to seek approval of … for £ … on … in support of …’

2. Strategic Context

Please provide an overview of the context within which the investment will be made. In other words, the strategy, work programme, service, project or operation, which the investment supports.

3. Case for Change

3.1 Business Needs

Please provide the compelling reasons for investment in the required services or assets, with reference to:

- The investment objectives for the procurement;
- The problems with the status quo, including the impact upon patient outcomes and quality metrics, as appropriate.

3.2 Benefits

Please provide a summary of the main benefits associated with the investment, distinguishing between qualitative and quantitative; cash releasing and non-cash releasing; direct and indirect to the Trust, as appropriate.

3.3 Risks

Please provide a summary of the main risks associated with the investment, distinguishing between business and service risks during the design, build and operational phases of the project, as appropriate. Qualitative risks that may arise prior to the operational realisation of benefits, must be specifically referred to here.

4. Available Options

Please provide a description of the main options (or choices) for investment, together with their relative advantages and disadvantages (a SWOT analysis including qualitative issues). Please bear in mind that:

- A minimum of four options should be considered, including the ‘do minimum’ or ‘do nothing’ (unless there are compelling reasons to the contrary);
- These options may differ in potential business scope, service solution, service delivery, implementation and funding, depending on the nature of the investment;
• The investment appraisal for each option should be contained as an appendix and prepared in accordance with the tools and techniques set out in the Capital Investment Manual and HM Treasury Green Book.

5. Preferred Option

On the basis of the above, please:

• State why the recommended option optimises value for money (VFM);
• Describe the services and/or assets required.

6. Procurement Route

Please state how the asset or service will be procured in accordance with the Government Procurement Agreement (WTO) and the EU Consolidated Public Sector Procurement Directive (2004). This may involve the use of an existing contract; a call-off contract or framework agreement; or the requirement for a new procurement under the above. Advice should be sought, as appropriate from the Head of Procurement.

7. Funding and Affordability

Please indicate:

• The capital and revenue costs of the proposed investment;
• How the investment will be funded. If this is to be funded directly by a third party, confirmation on the certainty of such funding being forthcoming should be included with any criteria that need to be met to release/secure such funding.
• Any affordability gap (as appropriate).

8. Management Arrangements

Please indicate how the investment will be delivered successfully with particular reference to:

• Project management arrangements: how will the project be managed and controlled?
• Business assurance arrangements (if applicable); what will happen to ensure that the proposal is implemented to deliver the investment objectives outlined in Section 3.1?
• Benefits realisation monitoring: how will it be clear that the benefits described in Section 3.2 are achieved?
• Risk management: how will the risks identified in Section 3.3 be mitigated?
• Post project evaluation (if applicable): Standing Financial Instructions require all business cases over £250K to undertake post project evaluation, which will be reviewed by the Board.
• Contingency plans (if applicable); for when things do not go to plan.
APPROVAL PROCESS

Before this can be considered at corporate level it must have been reviewed and authorised by the Division or Corporate Service level and formally signed-off via the relevant sub-committee prior to a request for consideration at Business Investment Committee.

Divisional/Executive Director

Signature ..................................................  
Name ..................................................  
Date ..................................................

Divisional General Manager/Corporate Head

Signature ..................................................  
Name ..................................................  
Date ..................................................

Divisional Head of Nursing

Signature ..................................................  
Name ..................................................  
Date ..................................................

(Divisional) Finance Manager

Signature ..................................................  
Name ..................................................  
Date ..................................................

IMPACT ON OTHER SERVICES - Where the business case impacts on other services this must be formally agreed and signed-off by the service lead:

Impact identified on [ENTER NAME OF SERVICE] and case approved for advancement by:

Signature ..................................................  
Name ..................................................  
Date ..................................................

Impact identified on [ENTER NAME OF SERVICE] and case approved for advancement by:

Signature ..................................................  
Name ..................................................  
Date ..................................................

Impact identified on [ENTER NAME OF SERVICE] and case approved for advancement by:

Signature ..................................................  
Name ..................................................  
Date ..................................................
Recommendation from Business Investment Committee:

Approve [ ] Do Not Approve [ ]

Reason for non-approval

This business case was: APPROVED [ ] REJECTED [ ]

By Business Investment Committee on [insert date] minute reference [insert reference]

By Trust Management Committee on [insert date] minute reference [insert reference]

Scrutinised by Finance & Performance Committee [insert date] minute reference [insert reference]

By Board of Directors on [insert date] minute reference [insert reference]

Director of Finance

Signature ………………………………………………………………………………………………………

Name ………………………………………………………………………………………………………

Date ………………………………………………………………………………………………………
**Business Case Approval Process**

1. **Communications Message**

   In accordance with the Trust’s Standing Financial Instructions (SFIs), where budget holders want to commit additional expenditure not currently budgeted for they need to submit a business case using the standard template in accordance with the process and financial approval limits contained in Appendix 4 of SFIs. Further detailed guidance is contained here.

   Please note that the key to this process is ensuring that robust business cases are produced at the outset and hence all such business cases must be signed off by the relevant triumvirate for divisions (Divisional Director, General Manager and Head of Nursing) or the Executive Director for Corporate Services, together with the appropriate Head of Financial Management on behalf of the Director of Finance. If this is done correctly there should be no unnecessary delays in approving business cases.

   Please note that in accordance with the requirements of the standard business case template (see Appendix 1), the sponsor of a business case must always be a Director of Clinical Services or an Executive Director.

   Any queries on the process should be directed to Mark Bloy, Deputy Director of Finance, in the first instance. He can be contacted on extension 7128 or via e-mail: mark.bloy@rothgen.nhs.uk.

2. **Detailed Guidance**

2.1 **When is a Business Case Required?**

   A business case is required for **ALL** schemes where:

   (a) Additional spend will be incurred or costs increased.

   (b) Allocated budget is requested to be used for a purpose other than that originally intended.

   (c) Service developments or changes to service delivery which increases costs permanently or temporarily.

   (d) All managerial and corporate services positions requiring interims require a business case to be approved prior to appointment.

   (e) Consultant appointments.

   (f) Information Technology and Estates related expenditure.

   (g) Where external funding has been identified a business case must be submitted to seek approval to spend against the allocated income.
2.2 Approval of Business Cases

2.2.1 There will be four forums where ALL business cases will be considered to support sound financial governance, namely:

(a) Business Investment Committee;
(b) Trust Management Committee;
(c) Finance and Performance Committee;
(d) Board of Directors.

2.2.2 Each of these forums will provide a different level of multi-disciplinary scrutiny and review process and make recommendations within the approval process and delegated limits outlined in Section 3 below.

2.2.3 This approval process will apply to all investment decisions (recurrent and non-recurrent) and will be the only method of additional budgets (capital and revenue) being allocated to divisions and corporate directorates.

2.2.4 The author is responsible for ensuring that a robust business case is produced at the outset and is also required to demonstrate that the business case has been reviewed and endorsed by the relevant experts via existing sub-committees. For example, IT related schemes will need to have been reviewed and approved via the Corporate Informatics Committee as regards to the appropriateness of the IT specification.

2.2.5 Non-compliance with the deadline for papers and appropriate sign-off from sub-committees and divisions will result in the business case not being reviewed and hence being delayed.

2.2.6 In line with the delegated approval limits referred to in Section 2.3 below, business cases will be submitted and discussed at all the relevant forums. Therefore, it is important that the standard template is used for all business cases as contained in Appendix 1.

2.2.7 This standardised process is required to support robust financial planning and forecasting, provide clarity and consistency to the divisions and corporate directorates and will provide additional assurance for the Board of Directors and NHS Improvement.

2.3 Business Case Approval Limits

2.3.1 Approval limits are as follows:

<table>
<thead>
<tr>
<th>Authority</th>
<th>Limit (£)¹</th>
</tr>
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<tbody>
<tr>
<td>Director of Finance²</td>
<td>&lt;£25,000</td>
</tr>
<tr>
<td>Business Investment Committee</td>
<td>£25,000 &amp; &lt;£100,000</td>
</tr>
<tr>
<td>Trust Management Committee</td>
<td>£100,000 &amp; &lt;£250,000</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>£250,000 and above</td>
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1. Figures exclude VAT.
2. Revenue expenditure only.
2.3.2 No other committee has authority to commit additional expenditure on behalf of the Trust, although Finance & Performance Committee will scrutinise all business cases above £250,000 before being considered by the Board of Directors.

2.3.3 It would normally be expected that any business case would be scrutinised by all levels of authority relative to the financial limit involved e.g.

- Business case value £50,000
  This will only require financial approval of Business Investment Committee.

- Business case value £150,000
  This will require approval of both Business Investment Committee and Trust Management Committee.

- Business case value £300,000
  This will require approval of Business Investment Committee, Trust Management Committee and the Board of Directors, with additional scrutiny from Finance & Performance Committee prior to the latter.

2.3.4 Business cases will only be allowed to by-pass any of these levels of authority in exceptional circumstances and with the express approval of the Director of Finance in advance of any meeting.

2.3.5 Where additional expenditure has already been approved in accordance with the above and there is a likelihood that this resource will be insufficient to fulfil the objectives of the original business case, then the budget holder must ensure that:

(a) This is brought to the attention of the Director of Finance as soon as is practicably possible;

(b) No additional expenditure is incurred beyond that already approved in the first instance;

(c) A revised business case is submitted in accordance with the limits above for the additional expenditure to be incurred.

2.4 Committee Scheduling Requirements

2.4.1 The dates of meetings are scheduled so that approval at all levels can take place during the same month, subject to adhering to the requirements of Paragraph 2.2.4 above. Usual dates are as follows:

(a) Business Investment Committee: First Wednesday of every month.

(b) Trust Management Committee: Third Tuesday of every month.

(c) Finance & Performance Committee: Third Monday of every month.
2.4.2 Papers, reports and supporting documentation will be prepared so that agendas for each of these meetings can be circulated to all members sufficiently in advance of each meeting to give members appropriate time to have read all documents. You should liaise with the chair person and/or lead officer for each meeting regarding scheduling items for each agenda, as dates for confirming inclusion of agenda items will be earlier than this. Contact details and indicative deadlines are as follows:

(a) Business Investment Committee

Chair Person : Simon Sheppard, Director of Finance  
Lead Officer : Mark Bloy, Deputy Director of Finance  
Support Officer : Helen Butler, Corporate Secretariat  
Agenda Deadline : 5 working days  
Circulation Deadline: 3 working days

(b) Trust Management Committee

Chair Person : Louise Barnett, Chief Executive  
Lead Officer : Louise Barnett, Chief Executive  
Support Officer : Sharree Johnstone, Assistant to Chief Executive  
Agenda Deadline : 7 working days  
Circulation Deadline: 5 working days

(c) Finance & Performance Committee

Chair Person : Heather Craven, Non-Executive Director  
Lead Officer : Simon Sheppard, Director of Finance  
Support Officer : Leanne Murphy, Corporate Secretariat  
Agenda Deadline : 7 working days  
Circulation Deadline: 4 working days

(d) Board of Directors

Chair Person : Martin Havenhand, Trust Chairman  
Lead Officer : Anna Milanec, Company Secretary  
Support Officer : Dawn Stewart, Corporate Governance Manager  
Agenda Deadline : 10 working days  
Circulation Deadline: 7 working days

Please note that it will be the responsibility of the Chair Person to determine whether there is any flexibility in varying these deadlines and therefore, to avoid any confusion or doubt and possible delays in considering business cases, sponsors and authors need to adhere to these deadlines.

2.4.3 Business cases that do not have the appropriate sign-off as stipulated in the standard business case template (see Appendix 1), have not been considered and endorsed by the relevant sub-committee (see paragraph 2.2.4) or have not followed due process in accordance with approval limits (see section 2.3) will not be included upon the relevant agenda.
2.4.4 Should a business case appear on such an agenda contrary to paragraph 2.4.3 above, then it is the responsibility of the chair person for that meeting to ensure that the agenda item is withdrawn and not discussed, in order to enforce correct governance and due process.

2.4.5 No business cases will be tabled at any of the forums referred to in paragraph 2.2.1 above.

3. Business Case Tracker

3.1 A business case tracker master document will be maintained by the Director of Finance to provide clarity on the status of all business cases.

3.2 It will be the responsibility of the Deputy Director of Finance to ensure that the document is updated accordingly after every meeting.

3.3 The business case tracker master document will also be used as an aide memoire to ensure post project evaluation is undertaken on all relevant business cases in a timely manner and reported to the relevant committee.
### Appendix 3 - Investments decision process

The process depicted below applies to all investment decisions (recurrent and non-recurrent) and is the only method of additional budgets (capital and revenue) being allocated to Divisions and corporate directorates.

Non compliance with the deadline for papers and appropriate sign off from Divisions will result in the business case not being reviewed.

**Approval thresholds**

<table>
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<tr>
<td>£250k+</td>
<td>Approval within Division prior to consideration as per below to stage 4</td>
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#### Stage 1

**Business Investment Committee (BIC)**

- Standard business case template and financial assessment
- Approval of business cases up to £100k. (Minutes of the meeting go to TMC for information)

#### Stage 2

**Trust Management Committee**

- Minutes & actions from committees above
- Approval of business cases from £100k to £250k following recommendation from BIC

#### Stage 3

**Finance and Performance Committee**

- Minutes from TMC for information
- Scrutiny of investment decisions over £250k to support decisions at the Board of

#### Stage 4

**Board of Directors**

- Minutes from Finance & Performance Committee for information
- Approval of investment decisions over £250k

#### Stage 5

**NHSI**

- Outline Business Case and Full Business Case submissions as required
Learning from Deaths Report

Presented by: Dr Conrad Wareham – Medical Director
Author(s): As above

Strategic Objective:
Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: safe / effective / caring / responsive / well-led

Risk Reference:
BAF: B1
Corporate Risk Register: No risks on risk register

Purpose of this paper:
This is the first quarterly report written following recommendations from the published National Guidance on Learning from deaths in March 2017.

Summary of Key Points:
The trust is committed in the three aspects highlighted within the report
1. Learning to improve and change the way care is provided within TRFT
2. Candour to support sharing information with others including families and carers
3. Accountability if failures are found.

Board action required:
For noting
1.0 Introduction

1.1 This is the first quarterly report written following recommendations from the published National Guidance on Learning from deaths in March 2017.

2.0 Background

2.1 Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards “from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals”.

2.2 This was reinforced by the recent findings of the Care Quality Commission report *learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source for learning.

The trust is committed in the three aspects highlighted within the report

1. Learning to improve and change the way care is provided within TRFT
2. Candour to support sharing information with others including families and carers
3. Accountability if failures are found.

3.0 What Has Been Done

3.1 All trusts currently undertake some form of mortality review. However there is considerable variation in the terms of methodology, scope, data capture and analysis and contribution to learning and improvement. The Rotherham General Foundation Trust has been a member of the Improvement Academy mortality group who have developed and had accepted as the standardised methodology to approach mortality reviews. This has been endorsed by the Royal College of Physicians and has been rolled out nationally since March 2017. The methodology had been embedded within the trust prior to the national launch and forms the structure of the mortality reviews.

3.2 Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided but the themes and trends alerted to by the reviews will allow the trust to implement quality improvements. Research has shown that when a case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but in combination can contribute to the death of a patient.

3.3 Some of these elements of care are likely to have occurred prior to the admission and the trust is working collaboratively with, for example, primary care to understand and act on areas where care could be improved.

3.4 To be assured that the approach to case record review is as consistent and variation is kept within standard limits a rolling programme of reviewer training in the methodology will be undertaken. For the trust to be assured of consistency a programme of validation will be undertaken. Although the process of mortality reviews within the trust is not a new concept it is a recent national focus and elements of the format will be subject to change when trusts become more familiar with expectations and organisational constraints.
3.5 As part of the quality improvement surrounding mortality the trust has undergone an improved system of data collection and reporting of mortality reviews and outcomes. This has now become electronic process connected to the Electronic patient record where death case reviews are stored, where previously this was a truly manual process, which involved many man hours of data input. The new dashboard will be published through the public board agenda. The data will include among other parameters the number of the Trust’s inpatient deaths and those deaths that the trust has subjected to a case record review, the trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care. Changes to the quality accounts regulations require the trust to publish the summarised data in Quality Accounts from June 2018.

3.6 NHS digital and Datix are currently working on a system which will allow interpretation of reviews by “word search” to identify elements of poor care and develop themes and trends for in depth analysis and quality improvements. This may replace the system on EPR that we currently use and would be a step forward to easily understanding elements of care to focus efforts on. This system is some time from completion and therefore the trust will continue to function as currently is until launch of a new system.

3.7 A list of recent in depth reviews with findings and actions is attached in Appendix 1.

4.0 Governance of Mortality
4.1 The executive medical director has responsibility for the learning from deaths agenda and the chair of the Quality Assurance Committee, an existing non-executive director has oversight of the progress.

4.2 Learning from a review of the care provided to patients who die is integral to the trust clinical governance and quality improvement work.

4.3 The Trust currently has a mortality and quality alerts group with stakeholders from divisional areas in attendance. The focus of this group is to on a monthly basis discuss the national mortality position and the data provided by CHKS to pick out areas where improvements can be made or where in depth review is required to understand the data. The governance arrangements ensure that due attention is given to those deaths that are determined more likely than not to have resulted from problems in care.

4.4 The national guidance on learning from deaths and the Serious incident framework are complementary. When a death meets serious incident criteria the onset of the investigation is not be delayed by a case record review. A review of the record will inevitably be undertaken as part of the investigation process.

4.5 The trust has recently undergone a review of the serious incident process and has introduced significant changes for quality improvement. This was following a peer review of the current process and implementation of best practice. The trust now holds a serious incident panel session weekly with executive direction on cases brought before it. The panel and the patient safety team have oversight of progress and hold divisions to account.

4.6 The trust now has a published mortality policy which includes the process for review, the escalations required of divisions following the review and the actions to be taken
if problems have been identified. This policy includes the process of learning from those deaths and the dissemination of the actions taken across the organisation.

5.0 **Bereaved Families and Carers**

5.1 The trust aims to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death.

5.2 Bereaved families will be informed of their right to raise concerns about the quality of care provided to their loved ones in a timely manner and these concerns will form part of the mortality review. They will receive timely responsive contact and support in all aspects of an investigation process if investigation is deemed necessary.

5.3 Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour are provided by the trust in dealings with bereaved families and carers. Although the Care Quality Commission’s report *Learning, candour and accountability* has identified that providers are continuing to fail too many bereaved families of those who die in their care this Trust aims to ensure that families receive a high standard of bereavement care.

6.0 **Learning Disabilities**

6.1 Since the 1990’s there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The confidential inquiry of 2012-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care three people with learning disabilities would do so. Overall currently people with learning disabilities have a life expectancy at least 15-20 years shorter than others.

6.2 The LeDeR programme has been introduced to ensure the operational aspects of mortality reviews of people with learning disabilities. The Trust is currently extremely active in the process involving the wider community services as the lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff.

7.0 **In Summary**

7.1 The trust is committed to implementing all recent national guidance on mortality reviews and learning from deaths. The national implementation is new and will be a fluid process as lessons will be learnt but the trust has been integral to developing the national process with its involvement with the improvement academy. Learning from the deaths and ensuring that these lessons are realised across the organisation will be the challenge.

Dr Conrad Wareham  
Medical Director  
September 2017
### Areas of focus for the trust

<table>
<thead>
<tr>
<th>What the data showed</th>
<th>What was realised</th>
<th>Actions taken</th>
<th>Results shown</th>
</tr>
</thead>
</table>
| **PNEUMONIA AS AN OUTLIER:**  
2 years ago the data was highlighting that the trust had an issue with the diagnosis code of pneumonia. | Following an in depth review of all cases retrospectively by an experienced respiratory physician it was seen that there was a significant discrepancy with the diagnosis and most patients did not have pneumonia.  
Of those with pneumonia improvements were needed | The pneumonia care bundle was introduced with CURB65 scoring to risk stratify patients and help signpost severity to critical care areas.  
The SEPSIS 6 bundle was advertised and reiterated more strongly | The trust no longer has a diagnosis code of pneumonia as an alert. |
| **PALLIATIVE CARE**  
The trust was coding higher than regionally regarding palliative care. | Advance care planning was needed in many more cases than at the time  
More resource was required within the palliative care team to support the volume of work required. | As per local standards only patients who have had a palliative care consultation can be coded as palliative care  
Stickers produced for easy identification within coding department.  
Following an in depth review in conjunction with the community services the palliative care team showed that advance care planning required much more resource but there were a few areas to focus to improve the situation.  
Palliative care team worked closely with the community services to increase the number of advance care pathways for long term conditions. | The trust is now in line with standard and has similar palliative care coding data.  
New advance care documentation has been launched |
### Areas of focus for the trust

<table>
<thead>
<tr>
<th><strong>HEART FAILURE AS AN OUTLIER</strong></th>
<th><strong>GP services were aiming if possible to treat patients within the community setting before sending to secondary care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data showed heart failure codes as an outlier</td>
<td>Variations from best practice was highlighted and disseminated. A follow up audit planned for this year to see changes and improvements. Unfortunately due to resource patients need still to be treated by general physicians with input and advice from cardiologists. Stricter definition of heart failure in patients to ensure accurate diagnosis. The diagnosis code of heart failure is no longer triggering. Consultant appointments in cardiology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>WEEKEND MORTALITY RATES</strong></th>
<th><strong>The trust took part in the 7 day service national review</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The trust data was showing that weekend mortality rates were higher than the week day</td>
<td>Focus on the weekend plan with senior colleagues prior to the weekend. Weekend handover documentation within the medical notes to aid with team decisions at the weekend. Extra medical consultant on the rota at weekends to enable post take ward rounds to be effective. The weekend crude mortality is slowly reducing. The data is slowly improving. Focus on patients who are at the end stage of their disease process. DNACPR completion rates much improved with a trust wide compliance of &gt;90%.</td>
</tr>
</tbody>
</table>

- **Weekend mortality rates** were higher than week days as was the national standard. Themes and trends were identified such delays with deteriorating patients. Patients admitted and died within 0-1 day were a significant group of patients.

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## Areas of focus for the trust

<table>
<thead>
<tr>
<th>Resource support within the trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deteriorating patient task and finish group with revised documentation and enhanced escalation procedures.</td>
</tr>
<tr>
<td>DNACPR task and finish group with increased awareness of patients at the end stage of their life and disease process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VASCULAR PROCEDURES AS AN OUTLIER</th>
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</thead>
<tbody>
<tr>
<td>As the trust no longer carries out vascular procedures (varicose vein surgery is not commissioned) it was concerning that this code was a problem.</td>
</tr>
<tr>
<td>This code was used when patients had invasive lines placed</td>
</tr>
<tr>
<td>The diagnosis code remains in use as this can symbolise seriously ill patients within the trust who require central lines/PICC lines</td>
</tr>
<tr>
<td>The diagnosis was not the cause of death and was a secondary code</td>
</tr>
<tr>
<td>The trust has a standalone vascular access team with outstanding results and very low catheter infection rates</td>
</tr>
<tr>
<td>the reasons the code was triggered was identified and dismissed as a concern for the trust at this present time.</td>
</tr>
</tbody>
</table>
Report: Mortality Policy

Presented by: Conrad Wareham – Medical Director
Author(s): As above

Strategic Objective: Patients: Excellence in healthcare
Colleagues: Engaged, accountable colleagues
Governance: Trusted, open governance

Regulatory relevance:
NHSI: Licence Condition FT4 / Single Oversight Framework
CQC Domain: Safe / effective / caring /responsive / well-led

Risk Reference:
BAF: B1
Corporate Risk Register: No risks on risk register

Purpose of this paper:
Following the release of a national report "Learning from Deaths" published by the CQC early in 2017, the Trust was required to produce a Mortality Policy. The Mortality Policy is presented to the Board. This will be ratified by the Document Ratification Group on 20 September 2017.

Board action required:
For approval.
MORTALITY POLICY

SECTION 1
PROCEDURAL INFORMATION

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</tr>
<tr>
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<td>Associate Medical Director, Standards of Medical Care</td>
</tr>
<tr>
<td>Title of responsible committee/individual:</td>
<td>Hospital mortality and quality alerts group Clinical governance committee</td>
</tr>
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<td>September 2017</td>
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1. **INTRODUCTION**

Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures and patient safety ratings for NHS Trusts. Following the conclusion of the public enquiry into standards of care in some foundation trusts a few were put into special measures to address concerns about the standard of care provided.

Recommendations from these hospital enquiries have led to an increased drive for NHS trust boards to be assured that patient deaths are reviewed and appropriate changes made to ensure patients are safe.

The recent findings of the Care Quality Commission (CQC) report *learning, candour and accountability: a review of the way NHS trusts review and investigate deaths of patients in England* showed that learning from deaths was not given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

The Rotherham NHS Foundation Trust (TRFT) is committed to continuously and systematically reviewing patient outcomes and this policy underpins this commitment. Based on national and local experience six criteria have been identified which characterise a successful review process

1. Clarify the purpose of the reviews
2. Conduct reviews regularly
3. Select cases systematically
4. Seek system issues and common themes
5. Share learning and feedback to clinical teams
6. Feed learning into strategy

2. **PURPOSE & SCOPE**

2.1 **Purpose**

This policy provides guidance for establishing a consistent, standardised and coordinated approach to the classification and review of deaths as part of a process based on the available evidence.

The Keogh report published July 2013 signalled the importance of monitoring mortality statistics to highlight any underlying issues around patient care and safety.

This policy recognises the need to consider mortality rates and national mortality indicators, available at diagnosis code level and patient safety indicator level.
Using mortality indices
Statistics on deaths of residents in England and Wales are published by the Office of National statistics (ONS) including age standardised mortality ratios (SMR). At population level, mortality trends are heavily influenced by lifestyle factors, socioeconomic circumstances, advances in healthcare, and preventative public health action. However trends relating to hospital mortality can contribute to the monitoring of healthcare quality and inform quality improvement action.

The monitoring of high level mortality indices is therefore an important component of quality assurance. A lack of attention to mortality indices was identified as one of the failings in the Mid Staffordshire NHS Trust and there is evidence that using mortality indices to identify quality issues could have also have helped detect other major high profile service failings, including child heart surgery at the Bristol Royal Infirmary and the criminal activity of GP, Harold Shipman.

Robert Francis himself said, 'it is in my view misleading and a potential misuse of the figures to extrapolate from them a conclusion that any particular number, or range of numbers of deaths were caused or contributed to by inadequate care' but until such time that a study is conducted into the relationship between ‘excess mortality rates’ and actual ‘avoidable deaths’ these indicators will serve as our trigger for review.

Although the extent of avoidable harm may be contentious its existence is not disputed and action is needed to reduce harm caused by suboptimal care.

The policy entreats us to develop a robust means of investigating avoidable deaths. This policy also recognises the role that staff and the public can play in identifying and reporting poor care.

Mortality case note reviews

The primary purpose of mortality case note reviews is governance and assurance to ensure that patients have not died because of unrecognised suboptimal care. However in addition to this high level assurance mortality reviews can reveal underlying themes about care quality, for example, poor communication between clinical staff, specific diagnosis and therapeutic issues, or situations where dignity and respect have been compromised.

As quality assurance mechanism, mortality reviews also complement other established sources of information for instance the post hoc reporting of incidents and near misses, and the investigation of complaints and service user feedback. This triangulation of information from different sources is an
important method of assurance in itself. It confirms the extent of robustness of general reporting and learning systems in the wider organisation.

It is therefore clear that reviews are not intended to be used in isolation. Achieving the level of learning required must involve the integration and triangulation of information from differing sources including individual stories.

The policy details the processes which aim to identify issues with regards to mortality to reduce avoidable deaths by ensuring all inpatient deaths are systematically reviewed and that recommendations for improvement arising out of mortality (death) reviews are considered regularly for implementation. This must be considered monthly by departments depending on the caseload. The involvement of clinical coding staff working alongside clinicians has an important positive learning point. Clinical staff will develop a positive understanding of the value of coding expertise and the way in which high quality record keeping underpins accurate coding. Meanwhile coding staff will have an understanding in the way in which their work underpins the development of indices to provide organisational assurance.

Areas of good practice must also be identified through regular review and supported. These areas of good practice will be championed through Clinical Effectiveness and Research Group meetings and disseminated throughout the trust for adoption at all directorates deemed appropriate.

The process will ensure that there are clear reporting mechanisms in place to escalate any areas of concern identified so that the trust is aware and can take appropriate action to ensure that real care improvements and relevant clinical learning stems from mortality.

2.2 Scope
This document relates to the review of mortality and morbidity for patients under the care of TRFT at the time of death. It covers patient case reviews and the monitoring of data and trends. The trust expects that all deaths are reviewed, and it will be possible to highlight certain diagnosis codes that warrant a “theme approach” to mortality reviews. It is the responsibility of the individual departments to list the mortality criteria specific to their subset of patients that warrant such themed review. For example surgical site infections as part of the surgical mortality review. The Hospital Mortality and Quality Alerts Group also holds responsibility to signpost the departments for themed review on receipt of mortality data sets.

3. ROLES & RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Roles</th>
<th>Responsibilities</th>
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</thead>
<tbody>
<tr>
<td>Hospital Board of Directors</td>
<td>Has an existing board level leader acting as Patient Safety Director (Medical Director) to take responsibility for the learning from deaths</td>
</tr>
<tr>
<td>organisation:</td>
<td>agenda and an existing Non-Executive Director to take oversight of progress (Chair of Quality Assurance Committee);</td>
</tr>
<tr>
<td></td>
<td>- pays particular attention to the care of patients with a learning disability or mental health needs;</td>
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<tr>
<td></td>
<td>- has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review;</td>
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<tr>
<td></td>
<td>- adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;</td>
</tr>
<tr>
<td></td>
<td>- ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;</td>
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<tr>
<td></td>
<td>- ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge.</td>
</tr>
<tr>
<td></td>
<td>- ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts</td>
</tr>
<tr>
<td></td>
<td>- shares relevant learning across the organisation and with other services where the insight gained could be useful</td>
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</table>
| | - ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and
| Medical Director (Executive Lead) | • Overall responsibility for ensuring the organisation has an overarching policy for the review of mortality.  
| | • Ensuring processes are in place for the implementation and monitoring of the policy.  
| | • Acting upon escalated issues.  
| | Ensure that through a paper and an agenda item to a public board meeting quarterly publish specified information on deaths within the trust. This will include total number of inpatient deaths including emergency department deaths and those deaths that the trust has subjected to case record review. There will be estimates |
Please check the intranet to ensure you have the latest version provided of how many deaths were judged more likely than not to have been due to problems in care (PRISM 5-6).

These responsibilities are delegated as described below.

| **Associate Medical Director, Standards of Medical Care** | **Promoting the requirements of the policy and ensuring Clinical mortality Leads take responsibility for implementation within their directorates.**  
| | **Holding individual departments or groups of associated specialities to account in relation to their Mortality reviews and associated outcomes.**  
| | **Facilitating the clinical effectiveness leads in the quality improvement projects decided by hospital mortality and quality alerts group.**  
| **Hospital Mortality and Quality Alerts Group** | **Receive alerts from external agencies regarding mortality data.**  
| | **Ensure that mortality data is reviewed and acted upon in a timely manner.**  
| | **Receive action plans from mortality reviews**  
| | **Peer review as a group predetermined diagnosis codes of concern to ensure trust wide implementation of recommendations. These are subject to change, examples of such are patients who have died following an elective procedure, patients <50 years of age, all patients subjected to a never event, a serious untoward incident and a Datix incident**  
| | **Decide quality improvement projects with regards to improving issues highlighted following mortality reviews in line with divisional and trust strategy.**  
| | **Ensure clinical effectiveness Department are aware of the planned quality improvement plans and the need to monitor progress.**  
| **Clinical Effectiveness leads/ mortality leads.** | **Maintaining the process for the review of mortality.**  
| | **Responsible for chairing the review meeting or deputising a more appropriate clinician who will then take responsibility for alerting governance within the department and the divisional**  

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance lead</td>
<td>Ensuring appropriate multi-disciplinary mortality review meetings take place within their directorates (in an appropriate existing forum or standalone meeting).</td>
</tr>
<tr>
<td></td>
<td>Responsible for reviewing mortality trending data and taking action as appropriate, including discussion at, and escalation to governance leads.. This will involve developing specified action plans. The learning from death reviews and the quality improvement from these will be the responsibility of the clinical effectiveness leads.</td>
</tr>
<tr>
<td></td>
<td>Ensuring appropriate representatives from other directorates are co-opted to the mortality meetings where appropriate.</td>
</tr>
</tbody>
</table>

| Clinical governance leads                  | Develop and ensure actions plans are completed of the recommendations following the mortality reviews. |
|                                           | Ensure that directors of clinical services are aware of the recommendations and action plans to ensure escalation to HMQAG. |

| Directors of clinical services            | The Directors of clinical services are responsible in alerting the hospital and quality alerts group when an avoidable death has been identified or there are substandard levels of clinical or organisational care noted from mortality reviews. |
|                                           | Ensure recommendations are completed. |

| All clinical staff, including trainees and students involved in clinical work | Fully participate in the mortality review process relevant to their practice, as directed by their clinical mortality Lead. This must include highlighting any cases that require review, contributing to reviews, contributing to discussions and the implementation of actions and learning points. |

| Clinical Effectiveness Department         | Support the quality improvement and the best practice development required within the divisions. Provide the governance structure surrounding the quality improvement projects. |
|                                           | Alerts the HMQAG when external. |
4. PROCEDURAL INFORMATION

It is expected that all deaths within The Rotherham NHS Foundation Trust will be subjected to a mortality review.

The national guidance on learning from deaths\(^1\) published in March states that at a minimum providers should require reviews of all deaths where

1. Bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.
2. All inpatient, outpatient and community patient deaths of those with learning disability (LeDeR process) and with severe mental illness.
3. All deaths in a service speciality, particular diagnosis or treatment group where an “alarm” has been raised with the provider through whatever means (for example via summary Hospital-Level Mortality indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).
4. All deaths where people are not expected to die for example in relevant elective procedures.
5. Deaths where learning will inform the provider’s existing or planned improvement work for example if work is planned on improving sepsis care such deaths could be reviewed thematically.

The above minimum are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the mental health act 1983.

The trust may decide that some deaths warrant an investigation and will be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. Where care will be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication is required to avoid problems.

\(^1\) National guidance on learning from deaths: a framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in Care National Quality Board March 2017.
This mortality review will take the format of structured judgement review with comments regarding the care given at all stages of the patient journey. Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care. The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

A nationally recognised score will then be given to the care and recorded within the review process. This scoring system has a scale for avoidability (PRISM) and a score for both clinical care given and organisation aspects of the care given (NCEPOD).

PRISM SCORING
1. Definitely not preventable
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

NCEPOD SCORING:
1: **Good practice**: A standard that you would accept from yourself, your trainees and your institution.
2: **Room for improvement**: Aspects of *clinical* care that could have been better.
3: **Room for improvement**: Aspects of *organisational* care that could have been better.
4: **Room for improvement**: Aspects of both *clinical* and *organisational* care that could have been better.
5: **Less than satisfactory**: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.
It is also very important that good care is highlighted within the mortality review document so that the trust can identify where this good practice may be transcribed elsewhere.

Standardised multidisciplinary mortality meetings held regularly at each clinical speciality level to review all deaths will be undertaken following an SBAR approach already adopted by the organisation. The goal being: to provide the team with the opportunity to discuss aspects of patient care where the outcome was not as intended, or anticipated, and to review errors and adverse events in an open and reflective manner.

The review meetings are a key component of work placed based learning and continuing professional development. They must be chaired by the clinical effectiveness leads or delegated to an appropriately qualified deputy (mortality leads). The flow chart for how mortality is reviewed at TRFT can be found at appendix 1.

The meetings structure must include presentation and review of patient death, review of the relevant literature to ensure evidence based practice is developed throughout the organisation. It must highlight recommendations made and clearly document learning points and action plans to prevent a future similar problem. These presentations can be undertaken by any member of the multidisciplinary team reviewing the death and not necessarily the most senior of that specific team but the discussion that ensues must involve senior medical members prior to agreement on the scoring applied to that death. Categorisation of the death must be done using the PRISM and NCEPOD scoring system. These meetings must be held monthly so learning points can be escalated promptly to avoid further patients being subjected to the same errors.

Following the individual department or associated groups of specialities mortality meeting escalation may be required to divisional governance leads and the director of clinical services. Escalation is also required to the Hospital mortality and quality alerts group if the scoring has shown an avoidable death (PRISM5-6) and/or organisational/clinical substandard care (NCEPOD4-5)

If the death is deemed unavoidable there may still be lessons to learn and these will be discussed within the individual CSU and carried forward though the relevant teams.

The HMQAG must receive escalations from the mortality review process and must expect an action plan and lessons to learn. It is the responsibility of HMQAG to agree those actions and generate quality improvement projects. The HMQAG will then inform the clinical effectiveness department of the proposed projects.

It is the responsibility of the clinical effectiveness leads to facilitate the quality improvement. It is the responsibility of the governance arm of the
division to complete the action plans from recommendations borne out of the mortality reviews.

Relevant time scales for both will be discussed within HMQAG and will remain on the group action log until completed and signed off.

It will be the responsibility of the clinical effectiveness group to monitor the quality improvement projects and progress will be monitored through this group and disseminated via the clinical effectiveness leads.

Both the minutes of the clinical effectiveness group and the governance groups are received by the clinical governance committee.

The Hospital Mortality and Quality Alerts Group will interrogate data relating to mortality, coded clinical data including crude and standardised data. It is the group responsibility to interrogate diagnosis codes of issue and action in depth review for themes and trends and learning.

It is the responsibility of this group to identify quality improvement projects using the themes and trends highlighted from mortality reviews. The clinical effectiveness leads will be available to oversee and manage these projects within their area and this will be fed back to the organisation through the clinical effectiveness department.

All issues highlighted by Clinical Effectiveness and Research Group will be escalated to the clinical governance group.

DEATHS IN PATIENTS WITH LEARNING DISABILITY
Since the 1990’s there have been numerous reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than those without learning disabilities. The confidential enquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who dies from a cause of death amenable to good quality care, 3 people with learning disability would do so. Overall people with learning disabilities currently have a life expectancy of at least 15-20 years shorter than other people. The lives of people with a learning disability often involve a complex array of service provision with multiple care and support staff. A cross sector approach to reviewing deaths of people with learning disability is imperative; one that includes families, primary and secondary healthcare, social and third sector care providers. This means that patients with learning disability will undergo a differing mortality review approach. This is covered in the Learning disabilities mortality review programme (LeDeR)

All deaths of patients with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review will receive an initial review of their death by independent, trained reviewer/reviewers. A full multi agency review is required if the criteria for the current themed priority review are met. (Death of a person from a black and minority ethnic
background or aged 18-24) or where an assessment of the care received by the person indicates deficiencies in one or more significant areas.

The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so that the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

This policy does not cover the complexities of how the trust investigates and reviews death of children and young people occurring within the trust. NHS England is currently undertaking a national review of child mortality review processes both in the hospital and the community. The creation of a national child mortality database is currently being commissioned. A further supplementary mortality review policy specifically for children will be available which incorporates the expectations described within Working together to safeguard children (2015). New statutory guidance on child death review will be published late 2017.

**LEARNING FROM DEATHS:**
Learning from a review of the care provided to patients who die must be integral to a provider’s clinical governance and quality improvement work. To fulfil the standards and new reporting set by the national quality board it is important that the trust ensures adequate governance arrangements and processes give due focus to review, investigation and reporting of deaths. The trust is committed to sharing and acting upon the learning derived from these processes.

The learning from death reviews will be disseminated through various processes. Deaths that are deemed unavoidable and have no clinical or organisational issues remain in the individual CSU domain. There can be elements of these deaths that derive learning from and this will be disseminated through the CSU.

Escalations to divisional governance will ensure divisional involvement and learning dissemination at divisional level. The avoidable deaths and ones whose care was deemed substandard with or without organisational substandard performance will be escalated to HMQAG with learning vertically driven in both ways.

Other processes for learning follow the serious incident framework where a death of a patient may be subject to a serious incident. The involvement with families and carers with this process follows the serious incident policy.

Learning can come from a complaint or litigation process but this is out with the scope of this policy.
BEREAVED FAMILIES AND CARERS
It is the trust intention to engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death.
Bereaved families and carers must expect a clear, honest compassionate and sensitive response to a death of a loved one. Bereaved families and carers must be informed of their right to raise concerns about the quality of care provided to their loved one. Their concerns will form questions asked within the mortality review process. The learning, candour and accountability identified that NHS providers are continuing to fail too many bereaved families and carers of those who die in their care. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. The principles of openness, honesty and transparency as set out in the duty of candour will be applied by the trust in dealings with bereaved families and carers. The letter will form part of the bereavement pack so that concerns can be realised early.

5. DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

MORTALITY – for the purposes of this policy, mortality relates to in-hospital deaths or deaths within 30 days of discharge from hospital.

Abbreviations

CEG  Clinical Effectiveness and Research Group
CHKS  Comparative Health Knowledge System
CSU  Clinical Service Unit
HMQAG  Hospital mortality and quality alerts group
HSMR  Hospital Standardised Mortality Ratios
SBAR  Situation, Background, Assessment, Recommendation
SHMI  Summary Hospital-level Mortality Indicator
TRFT  The Rotherham Foundation Trust

6. REFERENCES

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013. Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England DEC 2106

National guidance on learning from deaths: National quality board March 2017

Independent review of deaths of people with a learning disability or mental health problem in contact with southern health NHS foundation trust April 2011 to March 2015 December 2015
7. ASSOCIATED DOCUMENTATION

Clinical Effectiveness and Research Group (CEG) Terms of Reference

Hospital Mortality and quality alerts (HMQAG) Terms of Reference
Appendix (1)

Process for Mortality Review

Mortality review

Outcome of mortality reviews discussed within a stand alone mortality meeting or standing agenda item within other scheduled meeting such as clinical effectiveness/governance meeting.

All deaths and morbidity (CSU specific) are reviewed

(To ensure the attendance at these meetings is multidisciplinary and appropriate to ensure learning is cascaded to the whole service)

PRISM 1-4
NCEPOD 1-3

PRISM 5-6
NCEPOD 4-5

Peer review agreement on the scoring applied. Escalated to divisional governance meeting to ensure Director of clinical service is aware of the issues

Lessons to learn and quality improvement projects facilitated by clinical effectiveness leads. Communication between clinical effectiveness and governance is essential.

Escalation of cases to HMQAG with predetermined diagnosis codes will undergo another review and agreement/amendment of the original action plan and recommendations.

Lessons to learn and action plans of recommendations from reviews generated. Action plans to be received by the HMQAG. Agreement from group on action plans.

Quality improvement projects to be identified within the HMQAG and to alert CE department of these.

Completed action plans to return from governance leads to HMQAG for final sign off once all actions have been completed. Plan to remain on HMQAG action log until completed.

Quality improvement projects to be discussed and facilitated by clinical effectiveness department and escalated to CEG with outcomes.

Clinical Effectiveness & Research Group to escalate where necessary.
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Actions required (specify &quot;None&quot;, if none required)</th>
<th>Action by date</th>
<th>Person responsible (Name and grade)</th>
<th>Comments (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)</th>
<th>Status Enter: Abandoned, Complete, In progress, To start</th>
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Appendix 2

*Example of the letter to be received by bereaved families.*
Dear Mr/Mrs...

Please accept our condolences on the death of your loved one whilst undergoing care at The Rotherham General Hospital. It is with hope that you have found the care they have received to be of good quality and without issues.

As part of our good governance structure we are committed to reviewing all case notes of patients who have died under our care so as to learn from any areas where care may have been substandard or organisational issues where care could have been improved.

As part of the trust on going learning from deaths we would like to involve patient’s families and carers in the mortality review process and it is our expectation that concerns raised by families will play a part in this.

If you have felt that the care your loved one received was not of good quality and would like to raise your concerns regarding any aspect of the episode of care please contact the department where they had died and it will form part of the future recommendations and action plan generated from the death review process.

This does not need to be in the form of a formal complaint unless you would wish this to be the case and will not form part of the trust policy on responding to formal complaints but it can be extremely helpful in improving future care given to our patients when concerns are raised by those families that have suffered a death. If you do wish your concerns to become a formal complaint please could you contact the patient experience team who will deal with it according to policy?

Yours sincerely

Associate Medical Director Standards of medical care
Please check the intranet to ensure you have the latest version.
MORTALITY POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING
8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with members of the hospital mortality and quality alerts group.

9. APPROVAL OF THE DOCUMENT

This document was approved by the Trusts Mortality and Quality Alerts Group and the Clinical Governance committee.

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Document Ratification Group.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed 1 year after implementation in view of changing national picture and will be 3 years following unless such changes occur as to require an earlier review.

The Associate Medical Director, Standards of Medical Care is responsible for the review of this document.

13. DISSEMINATION AND COMMUNICATION PLAN

<table>
<thead>
<tr>
<th>To be disseminated to</th>
<th>Disseminated by</th>
<th>How</th>
<th>When</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Governance Team via policies email</td>
<td>Author</td>
<td>Email</td>
<td>Within 1 week of ratification</td>
<td>Remove watermark from ratified document and inform Quality Governance Team if a revision and which document it replaces and where it must be located on the intranet.</td>
</tr>
</tbody>
</table>
14. IMPLEMENTATION AND TRAINING PLAN

<table>
<thead>
<tr>
<th>What</th>
<th>How</th>
<th>Associated action</th>
<th>Lead</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy requirements</td>
<td>Presentation to members of CEG</td>
<td>Agenda item at CEG meeting</td>
<td>Quality, Audit &amp; Effectiveness Manager, Associate Medical Director, Standards of Medical Care</td>
<td>Within 2 months of ratification</td>
</tr>
<tr>
<td>Obtaining CSU data on trends</td>
<td>Offer of meeting/</td>
<td>Contact CE leads to offer</td>
<td>Quality, Audit &amp;</td>
<td>Within 3 months of ratification</td>
</tr>
<tr>
<td></td>
<td>Contact CE leads to offer</td>
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</tr>
</tbody>
</table>
for mortality and morbidity, including the use of CHKS

workshop with relevant leads

meeting/workshop to relevant staff

Effectiveness Manager, Associate Medical Director, Standards of Medical Care

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

<table>
<thead>
<tr>
<th>Audit/Monitoring Criteria</th>
<th>Process for monitoring e.g. audit, survey</th>
<th>Audit / Monitoring performed by</th>
<th>Audit / Monitoring frequency</th>
<th>Audit / Monitoring reports distributed to</th>
<th>Action plans approved and monitored by</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSUs are conducting case note reviews patient deaths</td>
<td>Monitor ELECTRONIC DATABASE</td>
<td>Quality, Audit &amp; Effectiveness Manager, Associate Medical Director, Standards of Medical Care</td>
<td>On-going</td>
<td>CEG</td>
<td>CEG</td>
</tr>
<tr>
<td>CSUs are conducting MORTALITY activity in line with Trust Policy</td>
<td>Annual review report to HMQAG</td>
<td>Clinical Effectiveness Leads</td>
<td>Annually</td>
<td>CEG and HMQAG</td>
<td>HMQAG</td>
</tr>
</tbody>
</table>

15.2 Standards/Key Performance Indicators (KPIs)

None.
# EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

**Document Name:** Mortality Policy  
**Lead Officer:** Associate medical director Standards of medical care  
**Date/Period of Document:** 18th August 2017  
**Directorate:** Trust wide  
**Reviewing Officers:** AMD standards of medical care

- **Function**  
- **Policy**  
- **Procedure**  
- **Strategy**  
- **Joint Document, with whom?**

**Describe the main aim, objectives and intended outcomes of the above:**

This document provides guidance for establishing a consistent, standardised and coordinated approach to the classification and review of deaths as part of a process based on the available evidence.

---

**1. Assessment of possible adverse impact against any minority group**

<table>
<thead>
<tr>
<th>Area</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Sex (Male and Female?)</td>
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<tr>
<td>Disability (Learning Difficulties/Physical or Sensory Disability)?</td>
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<td>Race or Ethnicity?</td>
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<tr>
<td>Religion and Belief?</td>
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<tr>
<td>Sexual Orientation (gay, lesbian or heterosexual)?</td>
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<tr>
<td>Pregnancy and Maternity?</td>
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<tr>
<td>Gender Reassignment (The process of transitioning from one gender to another)?</td>
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<td>Marriage and Civil Partnership?</td>
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**You need to ask yourself:**

- Will the policy create any problems or barriers to any community of group? No
- Will any group be excluded because of the policy? No
- Will the policy have a negative impact on community relations? No

**If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment**

---

**2. Positive impact:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Response</th>
<th>If yes, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote equal opportunities</td>
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<td>Get rid of discrimination</td>
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<td>Get rid of harassment</td>
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<tr>
<td>Promote good community relations</td>
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<tr>
<td>Promote positive attitudes towards disabled people</td>
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<td>Encourage participation by disabled people</td>
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<tr>
<td>Consider more favourable treatment of disabled people</td>
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<tr>
<td>Promote and protect human rights</td>
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**3. Summary**

On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
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<tbody>
<tr>
<td>HIGH</td>
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<tr>
<td>MEDIUM</td>
<td>LOW</td>
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<td>LOW</td>
<td>NIL</td>
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<tr>
<td>NIL</td>
<td>MEDIUM</td>
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<tr>
<td>MEDIUM</td>
<td>HIGH</td>
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</table>

**Date assessment completed:** 18th August 2017

- **Is a full equality impact assessment required?** Yes
  - **(documentation on the intranet)**

---

Please check the intranet to ensure you have the latest version.
Report: Register of Sealings

Presented by: Lisa Reid, Head of Governance
Author(s): Anna Milanec, Director of Corporate Affairs / Company Secretary

Strategic Objective: Governance: Trusted, open governance

Regulatory relevance: NHSI: Single Oversight Framework / Licence Condition FT4
CQC Domain: effective well-led

Risk Reference: BAF: B6
Corporate Risk Register: none specifically

Purpose of this paper:
To present to the Trust Board details of activity related to the use of the Trust Seal.

Summary of Key Points:
The Board is asked to note that the Trust Seal has not been used since the last report provided to the Board in March 2017.

Board action required: to note

Anna Milanec
Director of Corporate Affairs / Company Secretary
September 2017
## TRUST BOARD MEETINGS

<table>
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<th>Action tracker log no.</th>
<th>2017/18 Q1</th>
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### PROCEDURAL ITEMS

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### STRATEGY AND PLANNING

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<td>Plans for 2 year job planning process to be in place - verbal report to Bod in Sept, written report in October</td>
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<td><strong>P47</strong></td>
<td>Mortality Policy: Board to sign off</td>
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<td>Review of Board Planner</td>
<td>Chair</td>
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**Board Feedback presented by (part 2):**

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<th>SS LH EM HC CH PS CC GA CC BM CW</th>
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**BOARD ASSURANCE VISITS**

<table>
<thead>
<tr>
<th>Board Committee meeting dates</th>
<th>26 31 28 19 30 27 27 24 29 26 31 28 25</th>
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<tr>
<td>Board Meetings</td>
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<tr>
<td>Strategy &amp; Transformation Committee</td>
<td>8 13 10 8 12 9 12 11 6 18 15 14</td>
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<tr>
<td>Quality Assurance Committee meetings</td>
<td>25 19 16 14 11 8 8 12 10 7 12 9 14</td>
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<td>Strategic Workforce Committee dates</td>
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<td>Finance and Performance Committee</td>
<td>25 23 20 13 17 21 21 16 15 20 16 15 19</td>
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<tr>
<td>Audit Committee meeting dates</td>
<td>20 20 20 19 20 18 17 20 20 18 17 17</td>
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<td>Audit / QAC (extra dates for accts if necessary)</td>
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<tr>
<td>Nomination Committee meeting dates</td>
<td>13 8 14</td>
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<td>Remuneration Committee</td>
<td>17 18 18 18</td>
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<td>Corporate Trustee</td>
<td>15 19</td>
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<tr>
<td>Charitable Funds Committee</td>
<td>10 11 12 12</td>
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1) Dates in yellow text above are set as part of the 2017 schedule.
2) Dates appearing in green text are now proposed and have been distributed to board and committee members.
3) Dates highlighted in yellow are being revisited as they now clash with in-house/operational meetings where Execs are required elsewhere.
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<thead>
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<td><strong>TRUST BOARD MEETINGS</strong></td>
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<td>M8</td>
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<td>M11</td>
<td>M12</td>
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<td><strong>NEDs 1/4ly review of complaints</strong></td>
<td>GA (Q2)</td>
<td>HC (Q3)</td>
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